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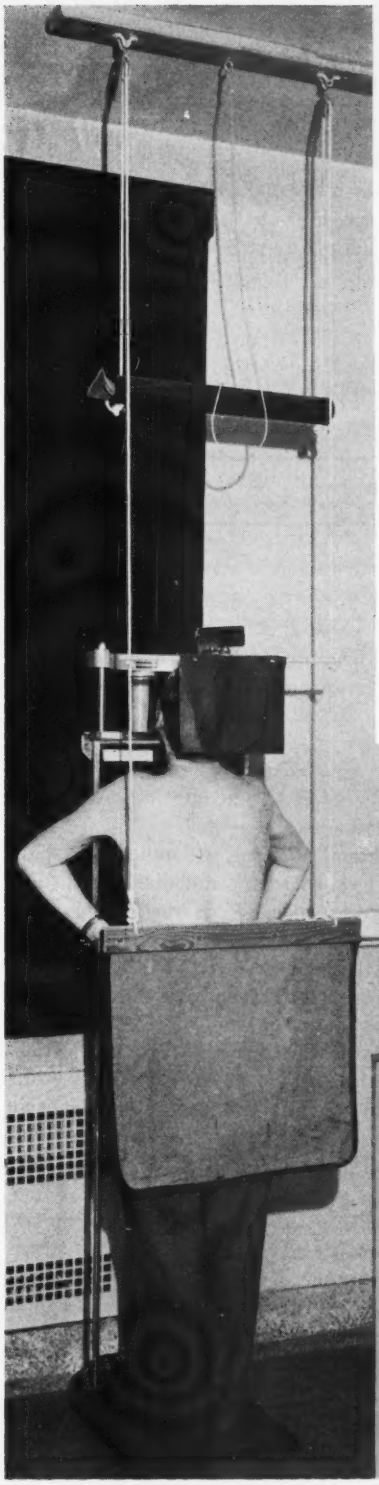

An easily constructed radiation shield is described. Suspended in front of the chest film holder, it reduces direct and stray radiation to the torso and the gonads. Once installed, it is difficult to circumvent its use and is easy to use properly.

Erich Goldmeier, M.D.

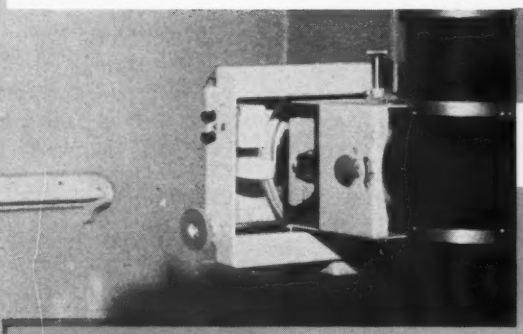

Fig. 1
View of the shield in use

RADIATION SHIELD for CHEST FILMS

Fig. 2
Diagramatic drawing of the shield

In response to the need to accomplish radiologic procedures with a minimum of radiation to the patient, a number of devices have been conceived. This paper is concerned with only one part of the problem, the decrease of gonadal dose in chest x-rays. The physical aspects of this subject have been well covered by Etter (1, 2). He has called attention to the large area of the trunk below the diaphragm which appears on the customary 14x17 chest film. Chest films in short adult women can actually include the gonads on the film, and the situation in children's chest films is even worse.

A number of devices have been suggested for upright chest films. Most of these are cumbersome shields which stand on the floor, either stationary or on wheels to be pushed into place. Their height has to be adjusted for each patient individually. Unless the lower edge of the shield is visible on the film, there is no assurance that the shield was actually raised up. These arrangements are inconvenient, and it is our impression that they are often ineffective as well.

At Perry Point Veterans Administration Hospital, we have constructed a radiation shield (Fig. 1) which is suspended from the ceiling, eight inches in front of the film, and which is lowered and raised by pulleys and counterweights. In addition to the shield for the body at the lower edge of the film, is a smaller shield for the head. The purpose of this is not so much to decrease the radiation to the head as to enforce proper leveling of the shielding device. Without it, the technician might put the shield at a too low level and leave it there, thus shielding only the legs rather than the abdomen.

We have adjusted the distance between the top and the bottom shield at 14.5 inches. This allows coverage of between fifteen and sixteen inches on the film. The technician is instructed not to show the head shield on the film. Therefore, at least one inch will be cut off at the bottom of the film. As

Illustrations prepared by Medical Illustration Service, Veterans Administration Hospital, Perry Point, Maryland.

the technicians become familiar with the device, they can cut off more and still leave the diaphragms visible. Once this shielding device is installed, it is more convenient to employ it than to sabotage it or use it improperly.

The device is easy to manufacture from parts obtainable in a hardware store (Fig. 2). The shields themselves can be made from discarded lead rubber aprons. Remember that the *upper* edge of the apron should be level with the *upper* edge of the wooden support, and the distance between the head shield and body shield should be 14.5 inches or less. The shield should be suspended so that it will rest lightly against even a thin patient, that is no more than eight inches in front of the position of the film.

The value of a shield of this sort is obvious in the light of our knowledge of genetic damage caused by radiation. How much stray radiation a patient's gonads receive depends, of course, on the care with which the primary beam is coned. It is a common experience for the operator to use too large a collimation for fear of cutting off part of the chest or simply because of forgetting to cone down (3). In actual practice, technicians tend to err on the "unsafe" side. The device described will help to rectify this situation.

It is easier to use this shield properly than improperly, and it is impossible to forget to use it. The opposite is true of coning devices or floor supported shields, which must be adjusted and hence can be made inoperative by simple failure to adjust them.

Over the past decade there has been considerable public awareness and fear of the danger of ionizing radiation. This has been a source of concern as well as of considerable annoyance to the medical profession. In response to this situation, leaders in the fields of radiology and dentistry have issued statements to calm and reassure the public (3). Such promises and pronouncements will serve their purpose only if the profession redeems these promises by actually improving procedures. Various devices, as well as reorientation on the part of the profession are necessary to translate our knowledge into safe radiologic practices. It seems urgent to decrease the time lag between availability of such knowledge and its application.

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ETHICS CORNER

Recently, instances have been brought to the attention of the Faculty Office with respect to release of patients' names to commercial organizations who wish to solicit the patients for purchase of certain products or services. In some instances, it has been found that an arrangement had been made with the physician's secretary for a list of the patients the physician was seeing, in return for which the secretary was reimbursed.

There is no question that such a practice is unethical. Physicians should impress upon their office assistants the necessity of keeping entirely confidential the names and records of patients.

Concept and Management of

HYDATIDIFORM MOLE and CHORIOCARCINOMA

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and
Richard F. Mattingly, M.D.*

In gynecologic practice, one finds a group of trophoblastic diseases characterized primarily by a benign, innocuous hydatidiform mole. Only a small percentage of these develop into choriocarcinoma, which represents the other extreme, being a highly malignant, rapidly terminating, fatal disease.

Between the two extremes is a group of histologically borderline conditions which is perplexing to the pathologist in making a proper diagnosis. For example, more than half of the diagnoses of choriocarcinoma, made by a competent general pathologist, were refuted by the Chorionepithelium Registry and were assigned to such categories as invasive mole, simple incomplete abortion, and syncytial endometritis.

Considerable knowledge of the trophoblastic diseases is lacking. The concept of some type of maternal defense mechanism at both the local uterine level and the systemic level is paramount in the attempt to explain the bizarre behavior of some of these unusual trophoblastic diseases.

The prognosis must always be guarded in any trophoblastic disease, but when hysterectomy has been carried out and the level of the chorionic gonadotropin remains high or is increasing, the prognosis is extremely poor. Chemotherapy in the latter case is highly advisable. While results are by no means good, chemotherapy remains about the only hope that one can offer a patient in this stage of her disease.

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JUDGING FROM CORRESPONDENCE and pathologic tissue slides submitted from outside sources, one of the clinician's most difficult problems is adequate management of the trophoblastic diseases. Hence, we are presenting this not as an original scientific piece of work, but as a brief résumé of our own methods of handling these cases. As such, we hope it lends some assistance to the average gynecologist, obstetrician, and pathologist in evaluating these equivocal cases.

A discussion of the diseases of the trophoblast is always difficult, for there are many aspects that are completely unknown and bewildering to even the most astute pathologist. It may help our understanding, however, to lay down a few fundamentals in regard to normal implantation; for these are paramount to comprehension of trophoblastic disorders. Body cells characteristically contain forty-six chromosomes, including the sex determinants. Before fertilization, however, the ovum, having been extruded from the ovary, undergoes a halfing of this number; so there are twenty-three. Similar changes occur in the male cell, but once fertilization has occurred, the full number of forty-six chromosomes (twenty-three pairs) will be restored. Fertilization takes place in the external third of the tube where the spermatozoa have migrated. Rarely, fertilization may take place in the region of the ovary, as evidenced by the occasional ovarian pregnancy.

Segmentation of the resultant zygote begins, with division into the blastomere and further subdivision until the ovum consists of a mulberry-like clump of cells known as the morula. Vacuolization of the morula subsequently takes place, and this we call a blastocyst. At one pole of the blastocyst is formed the so-called inner cell mass, which constitutes the embryonic area. Other cells form a lining around the cavity of the blastocyst, and these constitute the first trace of the trophoblast, which is so important in the development of the placenta.

During this period (about three days), the fertilized egg is slowly migrating down the tube. It does not become implanted immediately upon reaching the endometrial cavity, for implantation cannot occur until the chorionic villi have developed. The egg literally wanders aimlessly about the endometrial cavity, but by about the sixth day it is capable of implantation. The surface of the blastocyst has developed polypoid projections, which are spoken of as the trophoblastic buds. The component cells are differentiated into two types, the inner of which is termed the Langhan's cell; outside of this is the so-called syncytial cell. With the formation of these chorionic villi, the egg is now capable of implantation; the whole process has taken almost a week from the time of fertilization. Then the trophoblast literally erodes into the maternal decidua, simply ingesting it for nutritional purposes.

Ultimately the trophoblast burrows deeper and approximates the decidual vessels of the mother, although there is no frank communication of the circulatory systems. The erosive action of the trophoblast may penetrate the entire thickness of the decidua and actually extends into the myometrium itself. Thus the trophoblast shows one property that we associate with a malignant disease; namely, the ability to invade locally. At a certain point, however, in normal pregnancy, the growth of the trophoblast is more or less checked by an intangible maternal defense mechanism. Histologically this zone is recognizable as an area of hyalinized fibrin, the so-called layer of Nitabuch, although the actual mechanism involved is nebulous.

In addition to its locally erosive active, the trophoblast exhibits another property similar to the metastatic properties of malignant disease. It is by no means uncommon to find clumps and nests of chorionic villi in the lungs of pregnant patients who have died of other causes. This so-called *deportation of villi* is a well recognized phenomenon of pregnancy. Ober (1) has fully discussed this occurrence.

Trophoblastic cells, which are the source of the chorionic gonadotropic hormone, thus have two properties which we associate with cancer: *first*, the ability to invade locally, and *second*, the deportation of villi which is identical to a hematogenous metastasis. Indeed, it is a wonder that every woman who becomes pregnant does not die of this parasitic growth! About the only way we can explain this paradoxical situation and at the same time have any understanding of the vagaries of the trophoblastic diseases is to postulate some type of maternal defense mechanism. Whether it is in the nature of an antihormone, an antigen-antibody, or other agent is not known. There must, however, be some kind of barrier to prevent any

excessive overgrowth of trophoblast as it invades the myometrium and to cause the disappearance of the pulmonary emboli which are common during pregnancy. Both types of defense mechanism may be present or absent and act independently. This will be discussed more fully in connection with the various lesions.

Hydatidiform mole and its malignant counterpart, choriocarcinoma or chorionepithelioma, are generally discussed together, because they are both diseases of the trophoblast. Although there are some who consider hydatidiform mole a tumor, others such as Hertig (2) and ourselves believe that it is a degenerative process and similar to various abnormal ova found in certain abortions. The specific cause is thought to be an agenesis of the fetal cardiovascular system, which, in conjunction with the mother's normal one, allows a progressive accumulation of edema with the hydropic changes which are so characteristic of hydatidiform mole. It may, however, assume malignant characteristics and develop into a true neoplasm, choriocarcinoma.

Hydatidiform Mole

THE INCIDENCE OF hydatidiform mole in this country is generally given as one in twenty-five hundred pregnancies. In certain areas of the world, particularly the Far East, the incidence is much greater. Dr. Acosta-Sison (3), from Manila, has reported extensively on how common these diseases are in the Philippine Islands (one in two hundred pregnancies). While the cause for this disproportionately high incidence is not known, a protein-deficient diet has been suggested as a possible cause.

Grossly, hydatidiform mole resembles nothing more than a bunch of pale, grayish-green grapes, which are the enlarged vesicles. Molar changes may be complete or may involve only a portion of an otherwise normal placenta with a living fetus (4) or abortus (5). *Microscopically,* it is usually diffuse, involving the whole placenta without a recognizable fetus, and exhibits several distinctive features. The chorionic villi themselves are greatly enlarged, hydropic, and edematous. They are extremely myxomatous in appearance, with numerous areas of cystic degeneration and a paucity of blood vessels. Most important, however, from the standpoint of prognosis, is the increased amount of trophoblastic proliferation (Figure 1). Normally, the villi are lined by a simple

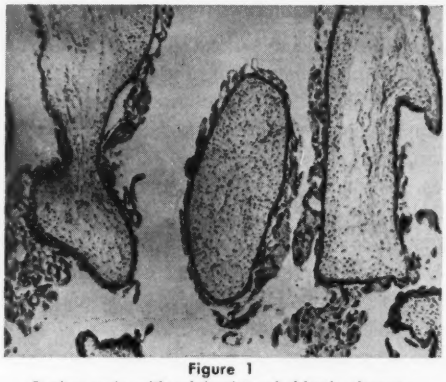
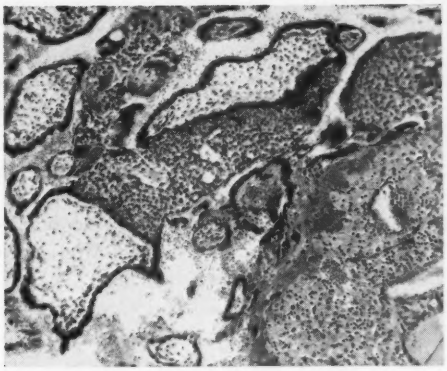


Figure 1
Benign mole with minimal trophoblastic change.

two cell layer thickness, but with mole there may be varying degrees of trophoblastic growth. Vacuolization is common with all the trophoblastic diseases and must be distinguished from a villus.

Clinically, a patient with a mole might present more or less the following type of story. She thinks she is pregnant, and her obstetrician confirms this. He may ask her if she is certain of the date of her last menstrual period, because he finds the uterus larger than anticipated by the expected date of confinement. She may or may not have bleeding. When she returns to her obstetrician, he will again be struck by the observation that the uterus is much larger than usual at this stage of pregnancy. He will not find a heart beat, however, nor will a fetal skeleton be visible on the x-ray film, even though the size of the uterus might suggest a pregnancy of fourteen to sixteen weeks. At any time, of course, the woman may have varying amounts of bleeding or cramps and may assume she is having an early abortion.

She may pass some of the characteristic grayish-green vesicles; and if she has the foresight to save these and bring them in to her obstetrician, the diagnosis will be apparent at once. If not, however, the obstetrician, if he is at all suspicious, will probably obtain an assay of the chorionic gonadotropin, (CGT), which is greatly elevated with hydatidiform mole, although such other conditions as multiple pregnancy may be confusing. It must be remembered that CGT is quite high during the first eight to ten weeks of pregnancy, after which it begins to decrease. Increasing titres after this period should always



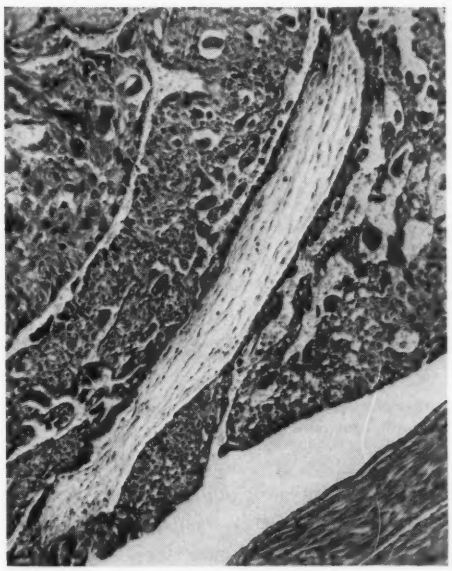


Figure 2
(a) Well developed villi with extensive proliferation of trophoblastic (predominantly Langhan's) cells.

(b) Overgrowth of trophoblast with severe vacuolization but obvious villous structure.

suggest the possibility of trophoblastic disease. Many patients so afflicted have an early toxemia of pregnancy.

Unfortunately, the problem is not always simple. If the obstetrician is fortunate, the patient will go on ahead and spontaneously evacuate the mole. If this does not occur, however, the uterus must be emptied. If the diagnosis is made early, this can be done by curettage. Diagnosis often is delayed because the obstetrician wants to be certain that he is not disrupting a normal pregnancy. If the uterus is enlarged to the umbilicus, hysterotomy is almost certainly a great deal safer than curettage, which can be attended by exsanguinating bleeding and the easy possibility of perforating a boggy, edematous uterus. Removed tissue is studied thoroughly.

After evacuation of the mole, a chorionic gonadotropin assay should be obtained every few weeks. The patient should be instructed not to become pregnant in the interim. If the CGT has not reverted to normal by two months after evacuation of the trophoblast, the possibility of a choriocarcinoma must be considered, although the increased level probably is due simply to residual benign trophoblast deep in the myometrium and inaccessible to the curette (syncytial endometritis). The importance of bio-assays has recently been pointed out by Delfs (6). Of eighty-one patients, seventy-three had their CGT revert to normal within two months; the remaining eight patients had either a malignant mole or a true choriocarcinoma. Posner et al (7) indicate the infrequency of repeated moles.

Invasive Mole

THE HISTOLOGY OF hydatidiform mole may be easy, but occasionally it can be confusing, for there is no hard and fast line between a benign mole and a locally invasive (so-called) malignant mole, also ineptly entitled chorioadenoma destruens. In this condition the trophoblast may invade the myometrium to a considerable depth and actually penetrate the entire thickness of the myometrium through the serosal surface. A number of deaths have been reported from hemorrhage due to a perforated uterus in conjunction with invasive mole. Penetration of the villi can also extend into the region of the broad ligament and down the vagina. This disorder does not, however, have the metastatic properties so common in choriocarcinoma. Certain authors, such as MacRae (8) do not recognize the invasive mole as an entity, preferring to utilize only "localized or generalized choriomas" as a means of classification. We consider this terminology too rigid, and the intermediate term is as useful as atypical hyperplasia, benign stromatosis, or implanting papillary tumors.

Histologically, a malignant mole shows primarily an increased amount of trophoblastic proliferation (Figure 2). Evaluation of the individual

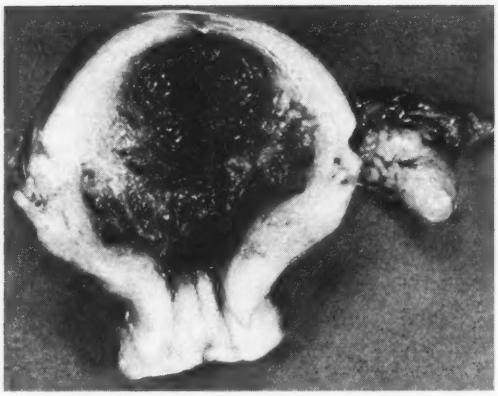


Figure 3
Typical choriocarcinoma, although myometrium is still grossly intact. Hemorrhagic grumose mass fills cavity.

cells with trophoblastic disease is difficult because they are uniformly juvenile, undifferentiated cells. With invasive mole, however, there are increasing degrees of trophoblastic proliferation, both Langhan's and syncytial cells. The basic histologic difference, which is the distinguishing factor from true choriocarcinoma, is that a villous pattern is generally preserved. While local extension to vagina or broad ligament may occur, distant metastasis is the exception, although transient lung foci may occur (19).

Choriocarcinoma

WITH CHORIOCARCINOMA, there is rarely a villous pattern. One finds an extreme degree of penetration of the myometrium with extensive necrosis, vacuolization, and hemorrhage (Figure 3). Probably no other neoplasm invokes such a tremendous tissue reaction, which is characterized by extensive coagulation of the myometrium (Figure 4), so that it may be difficult to actually distinguish necrotic muscle from trophoblastic cells. Appearance of the individual cells of the lesion in distinguishing between mole and choriocarcinoma is rarely helpful. Trophoblastic cells are always hyperactive and undifferentiated. Unquestionably, the most important differentiation between invasive mole and choriocarcinoma is that if a villous pattern is present, the suspect lesion is probably not a choriocarcinoma (Figure 5). Both syncytial cells and the Langhan's cells may proliferate, and it apparently makes no difference whether there is a predominance of one or the other. Either mole or choriocarcinoma may be a sequel to a tubal or ovarian pregnancy.

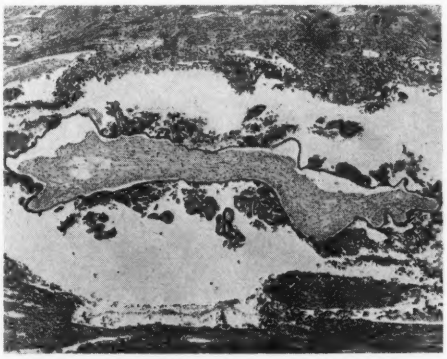
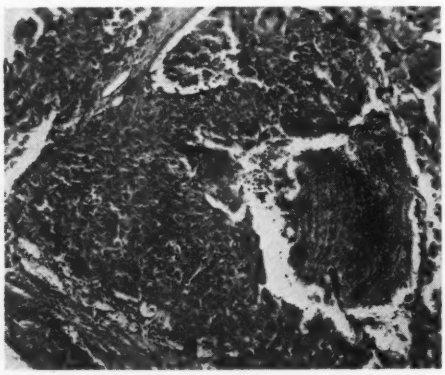


Figure 5
Although villous lies deep in the myometrium, its presence suggests merely an invasive mole.

Figure 4
Note extreme necrosis and coagulation of muscle due to impact of choriocarcinoma. Frequently the appearance of the trophoblast is obliterated because of hemorrhage.



From a clinical standpoint, there is no question that true choriocarcinoma is one of the most lethal types of malignancy with which a woman may be afflicted. Indeed, it used to be said that if a woman lived, she did not have choriocarcinoma. In a more recent study, utilizing material from the Chorionepithelioma Registry, which has been scrutinized by five expert pathologists, Novak and Seah (9) found that mortality was high but that there was a one-year salvage of 17 per cent with true choriocarcinoma. This seemingly short follow-up is valid, because choriocarcinoma is such a malignant disease that it usually kills its victim within six months of its inception.

Choriocarcinoma is an extremely rare disease. Hydatidiform mole occurs once in twenty-five hundred pregnancies, but only a few hydatidiform moles go on to the development of choriocarcinoma; certainly less than 5 per cent and probably about 1 or 2 per cent. On the other hand, choriocarcinoma is preceded by hydatidiform mole in approximately 40 per cent of all cases, by abortions in 35 per cent, and by pregnancy in 25 per cent. Choriocarcinoma of the ovary may occur without preceding pregnancy if there is abnormal development of trophoblastic tissues, as may be found in an ovarian teratoma or, occasionally, dysgerminoma (17). Obviously, however, pregnancy of some type generally precedes the development of choriocarcinoma. For this reason the patients are almost uniformly young, being in their teens or early twenties.

On the other hand, a few cases have been reported in post-menopausal women over 50. Crisp (10) has reported a case of choriocarcinoma of the tube coincident with a viable uterine pregnancy. Mercer et al (11) had described a choriocarcinoma occurring in both the mother and the infant; indeed, there is some question why this has not been reported more frequently in this characteristically hematogenous metastatic process, for these authors note only a single previous proven case.

Treatment

THE THERAPY OF TROPHOBLASTIC diseases is generally dependent on several different conditions but may be summarized as follows. The behavior of the chorionic gonadotropin must be correlated with the appearance of any removed tissue as well as with the clinical behavior of the patient. Let us assume that the diagnosis of a hydatidiform mole has been made. Ideally the patient will spontaneously abort the mole. If not, and a diagnosis be made early (which, unfortunately, is not the rule), curettage can be performed. Should the uterus be enlarged to the size of a twenty-week pregnancy, as it generally is, hysterotomy is carried out. Via this approach a much more thorough removal of the uterine contents can be carried out with less likelihood of perforation of the uterus or excessive bleeding.

Determination of the chorionic gonadotropin should be carried out within a month. If, however, in the interim, the patient should continue bleeding, and especially if the uterus is enlarged and boggy, a second curettage should be carried out. This can generally be more thorough than the initial one, as the uterus is at least partially involuted and not as soft as previously. Careful evaluation of the histologic features of all removed tissues should be performed. If, the patient continues to bleed and if the chorionic gonadotropin continues to show a high level or is increasing in amount, then, perhaps reluctantly, the careful clinician will go ahead and perform a hysterectomy. Unfortunately, in most cases nothing will be found except residual trophoblast deep in the myometrium, where it is inaccessible to the curette (syncytial endometritis) (Figure 6).

A considerable number of hysterectomies are being performed when there is no real need for it; however, no gynecologist should be criticized for performing such hysterectomies, for it is with a real hope of curing an occasional case of early choriocarcinoma. It is well established that only about 25 per cent of all cases of choriocarcinoma are detectable by virtue of curettage and approximately 50 per cent by hysterectomy, but many are not detected until autopsy.

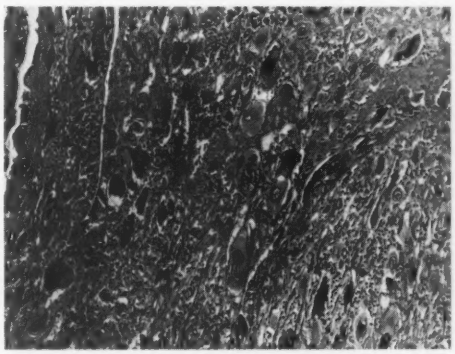


Figure 6

Syncytial endometritis; note clumps of cells lying deep in the myometrium.

Correlation of histologic features of removed tissue with the behavior of the chorionic gonadotropin is imperative. Nearly 10 per cent of cases in which there is genuine choriocarcinoma (as manifested by the appearance of pulmonary metastases at autopsy) reveal no evidence of choriocarcinoma when the uterus is removed. One might hypothesize that there has been a general-

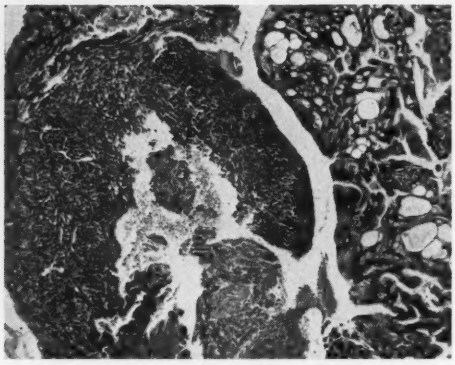


Figure 7

Severe vacuolization of tumor. The appearance of individual cells which are always juvenile and undifferentiated is not nearly as helpful in diagnosis as is their collective behavior.

ized breakdown in the local and the systemic defense mechanism, thus allowing the trophoblastic disease to spread to the lung. At a later date, and unfortunately too late to be helpful to the patient, there has been a resurgence of the local defense mechanism (Figure 7), thereby obliterating the disease in the uterus, although the patient may subsequently die of the extra-uterine manifestation.

We would reiterate the extreme importance of bio-assays of chorionic gonadotropin in every patient who has had a previous hydatidiform mole. As previously mentioned, however, it is the nature of the trophoblastic diseases for chorionic villi to penetrate to some distance in the myometrium and thus not be accessible to even vigorous curettage. Hence, these plugs of trophoblast may be responsible for increased titres which will cause the clinician to suspect choriocarcinoma and thus carry out hysterectomy. Conversely, a certain number of cases of malignant chorionepithelioma are not associated with an increased chorionic gonadotropin and may have a perfectly normal negative pregnancy test (12). In such cases it is assumed that the tumor is too anaplastic to manufacture the specific hormone or that there is no access to the maternal circulation. A rising titre of hormone following adequate hysterectomy is an extremely ominous sign, however.

Cystic ovaries (Figure 8) are frequently found with either a benign hydatidiform mole or its malignant counterpart, choriocarcinoma. The so-called lutein cysts actually represent a proliferation of the theca lutein cells. Probably they represent a response to the excessive amount of chorionic gonadotropin excreted by the proliferative trophoblast. In any case, they have no malignant potential; with benign mole they will regress after evacuation of the uterine contents. We know of a few cases in which there subsequently occurred torsion of the ovarian pedicle as with any benign ovarian cyst; but, by and large, once evacuation of the mole has been accomplished, the enlarged theca lutein cysts will regress. These, it might be added, are not pathognomonic of hydatidiform mole or choriocarcinoma.

Treatment of choriocarcinoma consists of total removal of the uterus. Most operators elect to remove both adnexae even though the patients are frequently in their teens or twenties. Frankly, we cannot help but feel that it might be well to preserve at least one ovary. If the disease represents true chorionepithelioma which has extended to the ovary, it is probable that the patient will die irrespective of whether or not she has had a bilateral adnexectomy. If the disease has not extended to the ovaries, obviously ovariectomy is not necessary, and preservation of the ovaries might thereby be rationalized in these young patients. Indeed, Smallbraak (13), writing from Utrecht, feels strongly that castration should not be carried out. It is his contention that the ovaries, by virtue of a liberated estrogenic hormone, tend to decrease the gonadotropin. While perhaps true, it apparently does not alter an almost inevitable fatal outcome.

Figure 8

Large cystic ovaries seen with mole or choriocarcinoma.

In any case, if hysterectomy has been carried out and the level of CGT remains elevated or increases, the prognosis is uniformly bad. It is im-

perative that x-ray examination of the chest be carried out in every known or suspected case of choriocarcinoma, because of the extreme tendency of this lesion to metastasize via hematogenous channels to the lung, liver, and brain. Choriocarcinoma is an extremely malignant type of neoplasm with rapid metastasis and death. In the event of an increased titre after hysterectomy, some form of chemotherapy is the only possible means of treatment. In previous years, various hormones, such as testosterone and estrogen, were utilized with the hope of inhibiting the elevated CGT.

At the suggestion of Dr. Roy Hertz (14), however, medical therapy today consists almost exclusively of the use of Methotrexate. This is an antifolic acid derivative, potently toxic to decidua. Dr. Hertz has indicated a striking remission in patients who have had either an invasive mole or a genuine choriocarcinoma. His series of twenty-seven cases, published in 1958, contained nineteen cases reported as choriocarcinoma with complete remission in five patients, partial remission in seven, and transient remission in ten. A more recent publication enlarges on this study. Perlson and Whitsitt (15) have furnished a more recent report. Our own results at Johns Hopkins, with a smaller number of patients, had been less rewarding; perhaps acceptance of this new drug should be with some reserve. Nevertheless, its use seems strongly indicated when the CGT is elevated after removal of the pelvic organs (18). Just as we recognize irradiation and bacterial resistance and sensitivity, there are apparently varying degrees of chemotherapeutic response.

One of the most striking features of choriocarcinoma is the radiologic findings. X-ray of the chest represents merely interpretation of shadows. It is probable that many of the reported cases of metastatic chorionepithelioma to the lungs are simply local areas of bronchopneumonia or small pulmonary emboli. However, there have been a number of cases in which seemingly specific metastatic lesions in the chest have regressed after hysterectomy alone. Others have been observed to regress after radiotherapy of the chest area or after the newer chemotherapeutic measures. In recent years, since the development of safer methods of chest surgery, actual lobectomy and pneumonectomy have been done with apparently typical choriocarcinoma; certainly an increased longevity has seemed likely in some patients. Such thoracic operations deserve consideration even though one must realize that choriocarcinoma, which spreads in diffuse fashion like sarcoma, probably has a poor prognosis despite removal of an apparent solitary metastasis of the chest.

Behavior of Trophoblastic Disease

THUS WE FIND at one extreme a benign mole and at the other extreme the highly malignant choriocarcinoma with intermediate degrees of the invasive mole. No clear line of demarcation may be made. The usual choriocarcinoma is a highly malignant type of neoplasm, while the mole is benign; but all kinds of inexplicable vagaries of trophoblastic disease may be found.

We know of a patient who had a hydatidiform mole treated by hysterotomy. Microscopic sections were extremely innocuous with only minimal trophoblastic proliferation, yet the level of the CGT remained high. After a year she was referred to Baltimore. Her sections were reviewed, and her chorionic gonadotropin was reassayed and again was found to be high. After careful deliberation, hysterectomy with bilateral salpingo-oophorectomy was performed without any evidence of trophoblastic tissue in the removed pelvic organs. There was a temporary decrease in the level of the CGT, but a year later the level rose. Within another year the x-ray films showed evidence of pulmonary metastases. Lobectomy confirmed the presence of choriocarcinoma, and the patient ultimately died. How can we rationalize such a case unless we assume that innocuous trophoblast must have permeated into the region of the broad ligament and remained dormant there for some months before acquiring metastatic potentialities?

One must assume that some type of systemic defense mechanism guarded against generalized spread, even though there had been at least a temporary collapse of the local barrier, allowing extension beyond the confines of the uterus. At some later date, breakdown of the systemic maternal mechanism occurred with conversion of residual trophoblast into true choriocarcinoma, metastasis to the lungs, and ultimate death.

We are likewise familiar with a patient who had a fairly typical hydatidiform mole which was treated by evacuation of the uterus. When the level of the CGT remained high, she was subjected to hysterectomy, which again revealed only a nonproliferative pattern of mole. A few months later x-ray films gave evidence of metastasis, but lobec-

tomy showed only a benign villous pattern in the lung. Notwithstanding this, the patient died of metastasizing but histologically benign hydatidiform mole. Indeed, there are some, such as Logan and Motyloff (16), who suggest that the histologic appearance and activity of an initial hydatidiform mole is no index to its future behavior. We agree that this occasionally may be true, but, by and large, the histologic activity of the mole is a moderately good prognostic criterion, but should always be correlated with CGT and the clinical course. Both aforementioned cases obviously represent highly atypical behavior of hydatidiform mole and choriocarcinoma and are not illustrative of the usual course of true choriocarcinoma.

More typical is the story of an unmarried 16-year-old girl who became pregnant. Criminal abortion was carried out, but the patient continued to bleed and had an enlarged uterus. Curettage was repeated, and there was a highly atypical appearance with no evidence of chorionic villi. CGT was high. The patient was flown here from her home in South Africa, and repeat curettage and bioassay were carried out. Again the curettings showed a highly suspicious pattern, and the gonadotropin was extremely high. X-ray examination of the chest was negative. After consultation with the parents, hysterectomy was carried out, which showed typical choriocarcinoma. By the time the patient was ready to leave the hospital, less than two weeks postoperatively, x-ray films of the chest showed evidence of a metastatic lesion. She returned home by airplane and died within two months of her arrival. This case typifies the extremely explosive behavior of choriocarcinoma, which is the general nature of this disease.

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OPINIONS EXPRESSED ON MULTIPLE SCREENING IN BALTIMORE

The opinions of participants in a multiple screening clinic, held in Baltimore in 1954, were solicited by means of two questionnaires. The first was mailed six weeks after the clinic closed, and the second was sent out five years later. An analysis of the replies indicates that a multiple screening program would be acceptable to the general public.

Charles M. Wylie, M.D., and Rose Mary Jacobs, M.A.

IN THE PAST DECADE, physicians' views have differed widely on the value of multiple screening. Their statements have ranged from enthusiastic endorsement of the procedure (1) to its complete condemnation as "unsound in its concepts, untenable in its principles, and indefensible in its logic" (2).

While physicians have had full opportunity to give their views, little is known of the opinions of those who have taken screening tests. Of course, a new medical procedure cannot be valued merely because large numbers of patients desire it; its true value should be measured by the extent to which the procedure helps the patients. However, a new community health program may fail to improve public health when it proves so unpopular that large numbers fail to participate. For this reason, it is useful to know what patients themselves think about a newly introduced program and to determine the percentage of persons willing to participate.

Background to this Study

SCREENING TESTS are widely known as procedures which sort out persons who probably have abnormalities from those who probably do not (3). Screening tests are applied to apparently well persons. Those persons with positive results are referred for more thorough diagnostic examination and, if it is found necessary, for treatment. The most widely used test in the United States has been the miniature chest x-ray, aimed primarily at the early detection of pulmonary tuberculosis.

The 1954 Baltimore clinic used the following tests: blood pressure measurement, six-lead EKG, 70 millimeter chest x-ray, blood and urine sugar tests one hour after a glucose drink, and urine albumin, in addition to two questions about discomfort on exertion. These were classified as major tests; individuals with positive results were referred to their family physicians for more com-

plete examinations. Additional minor tests included hearing, vision, and dental examinations and height and weight measurements; the results of these tests were not used for referral.

Of 6,967 Baltimore residents over 16 years who were invited to attend, 2,023 took the tests during the period October through December, 1954. The results of this program have been fully presented elsewhere (3-7). Six hundred and seven individuals were referred to their personal physicians because of positive major tests.

The Six-week Questionnaire

SIX WEEKS AFTER the clinic had closed, questionnaires were mailed to the six hundred and seven individuals who had been referred to their physicians. The primary purpose of this step was to determine what proportion of referrals had visited their physicians. One of the questions asked was: "Are you yourself pleased that you visited the screening clinic?" Of five hundred and thirty-three people who returned the questionnaire, five hundred and fifteen checked YES, three checked NO, and fifteen checked DON'T KNOW. It is thus apparent that the overwhelming majority of those with positive tests had favorable attitudes toward multiple screening soon after participation in the program.

The Five-year Questionnaire

IN EARLY 1960, five years after the clinic had closed, questionnaires were mailed to all 2,023 persons who had attended. The primary purpose of this questionnaire was to get information from those screened regarding their health problems in the five years after completion of the tests.

One question asked was: "If a second Multiple Screening Clinic were organized in cooperation with your personal physician in Baltimore, would you be interested in attending again?" Of the 1,528 who answered this question, 1,238 checked YES. Thus, affirmative replies came from 81 per cent of those returning the questionnaire, or from 61 per cent of all those to whom the questionnaire was mailed. It was again apparent that the majority of those screened still had a good opinion of multiple screening five years later.

A second question invited suggestions as to how a future clinic might better help the person screened. Only eight hundred and forty-eight persons (42 per cent of those screened) replied to this question. Of these, one hundred and seventy-five simply wrote that they had no suggestions for improvement. Three hundred and seventy-nine persons made remarks indicating approval of the 1954 clinic, while one hundred and thirty-one had suggestions indicating some unfavorable impressions.

The largest single group of favorable comments came from one hundred and sixty-nine persons who felt that they had personally benefitted from multiple screening. Ninety others indicated that such programs had considerable value to the community as well as to the individual. Seventy persons commented favorably on the operation of the clinic and the courtesy of the personnel, and twenty-three persons emphasized the "thoroughness" of the series of tests.

Of the one hundred and thirty-one persons making unfavorable remarks, thirty-nine preferred that the test results be sent directly to them rather than to their family physician; forty-five mentioned an unduly long wait before taking the tests or the "inconvenient hours" at which the clinic was held; twenty-four persons reported adverse effects after the tests, including local infection following venipuncture; and eighteen suggested that medical advice or follow-up examinations should be offered by the clinic. No respondent commented that he felt that multiple screening adversely affected the relationship with his family physician. The possible problem of interference with the doctor-patient relationship has been a serious worry to physicians and public health administrators, and it is reassuring to have this negative finding.

Most of the concrete suggestions for improving future clinics consisted of requests for additional tests. Most popular was a cancer detection test, suggested by fifty-eight persons. Twenty-eight simply asked for more frequent screening programs.

In brief, therefore, the great majority of replies suggested satisfaction with the clinic itself. The suggestions for improvement consisted mainly of requests for tests which the individuals felt to be important. The unfavorable remarks were varied.

The five-year questionnaire was mailed also to a one-in-five sample of those who had been invited to the clinic in 1954 but failed to attend. Of 1,021 questionnaires mailed, four hundred and

fifteen were answered. Of the non-attenders, two hundred and three (49 per cent of those returning questionnaires) replied that they would attend a future clinic. It is unlikely that this high proportion of all non-attenders would have this favorable opinion. On the other hand, it is apparent that many non-attenders had favorable views of multiple screening and that their non-attendance at the 1954 clinic was not entirely due to dislike of the screening procedure itself.

Discussion

THE 1954 CLINIC was the first multiple screening program to be held in Baltimore. Multiple screening was thus an unfamiliar procedure to those invited, and only 29 per cent came in to take the tests. Since invitations were sent to 6,967 persons scattered throughout Baltimore, there was little chance for one invitee to meet another who had actually taken the tests and thus to obtain first hand information on the new experience. This lack of person-to-person spread of information was probably the major reason for poor participation in the program.

The first questionnaire, mailed to those with positive major tests, showed that 97 per cent of respondents had favorable opinions on multiple screening and would probably encourage their friends to attend. The second questionnaire, mailed five years later to all those who attended, showed that 81 per cent of respondents would attend a future multiple screening program. From their suggestions for improving the second program, it was apparent that they were satisfied with the original clinic. The second questionnaire also showed that significant numbers of the original non-attenders would be interested in attending a future screening clinic.

The conclusion seems justified that a multiple screening program, offered as a community health project in the Baltimore area, would receive considerable support from the general public. We must still prove, however, that multiple screening is an effective method for the early detection and treatment of disease in the community. That problem we shall leave for a separate paper!

Acknowledgement: Mrs. Janet Hare contributed significantly to this study.

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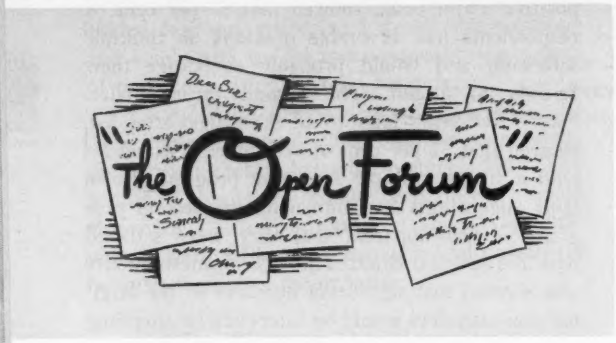


MEDICAL CARE FEES

October 9, 1961

The Home and Office Medical Care Program for the counties of Maryland was established in 1945, and basic fees were established for physicians at $2.00 for an office visit, $3.00 for a house call during the day, and $4.00 for a house call during the night. These fees have been unchanged since the program was established.

With the passage of the Kerr-Mills Act and Maryland's participation in the provisions of this law, increased numbers of people over 65 are eligible for home and office care under the Medical Assistance for the Aged Program. During the first three months of operation of MAA, nearly 5,000 elderly people have been accepted for care, and this number will rapidly increase due to a recent liberalization of eligibility requirements. The provisions and the fee schedule under MAA are nearly identical with those of the care program that has been in force since 1945.

It has been recognized that the fee schedules under these programs are not realistic in view of present economic conditions and the expense involved in the dispensation of medical care. Therefore, a request has been made by the State Board of Health and Mental Hygiene for an addition to the budget for 1962-1963 to allow a $1.00 increase in fees for home and office visits by the physician and dental visits. On March 21st, the Council of the State Medical Society took the following action:

"On motion duly made, seconded, and carried, it was voted that: 'The Council of the Medical and Chirurgical Faculty concurs with the Medical Care Section of the State Department of Health that certain changes in the Medical Care Program are desirable to upgrade the program and improve care to indigent patients.

'If it will materially assist the program by increasing the Physician's Fee for Service or providing a fee for special services, the Council of the Medical and Chirurgical Faculty of Maryland sanctions such an increase in fees.'"

The support of the medical profession is necessary for this budgetary increase to be accepted by the legislature. When an opportunity presents itself to the physicians of the State for an expression of opinion of the need for an increase of fees, remember:

1. The medical profession did not initiate the action for increased fees.
2. The 1945 fee schedule logically needs revision.

J. Roy Guyther, M.D., Chairman
Physicians Service Committee
Committee of Medical Care
Maryland State Department of Health

We invite you to share your views, to compliment or to critize, to support or to refute ideas and issues of concern to Maryland physicians. Address your letters to The Open Forum, Maryland State Medical Journal, 1211 Cathedral Street, Baltimore 1, Maryland. Please keep your letters brief and to the point. Your name and address must be included, but we will withhold your name upon request. Errors in grammar, spelling, and punctuation will be corrected unless you specify that the letter be published as is. Opinions expressed in The Open Forum are not necessarily those of the editor of the Maryland State Medical Journal or of the Medical and Chirurgical Faculty.

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

DR. LISANSKY ADDRESSES THE SOCIETY

E. T. Lisansky, M.D., associate professor of medicine and assistant professor of psychiatry at the University of Maryland, was guest speaker at a recent dinner meeting of the Allegany-Garrett County Medical Society. His subject was "The Changing Pattern of Human Illness and its Impact on the Practice of Medicine." Dr. Lisansky stressed the following:

1. Importance of careful history to determine the personality profile of the patient.
2. Relation between personality factors and the epidemiology of chronic illness.
3. Changing patterns of illness due to changing social service cultural concepts.

The meeting was held at the Cumberland Country Club.

DR. BAUMGARTNER HONORED BY STATE MEDICAL UNIT

E. I. Baumgartner, M.D., of Oakland, has been presented a distinguished service award by the Maryland Academy of General Practice. At the annual dinner of the Academy, held recently at Tidewater Inn, Easton, the award was bestowed on Dr. Baumgartner "for his tireless efforts in effecting the organization of the Maryland chapter, for his guidance as president, secretary, and director, and for his devotion to the cause of the general practitioner as director of the American Academy of General Practice and as secretary of the General Practice Section of the American Medical Association."

Dr. Baumgartner served as secretary of the Maryland Academy from 1949 until 1952, when

(Left to right): John A. Moberly, superintendent of Memorial Hospital; George M. Simons, M.D., President Allegany-Garrett County Medical Society; Mrs. Simons; Dr. Lisansky; and Mrs. Himmelwright, wife of O. G. Himmelwright, M.D., vice president of the Society.

he became its fourth president. He has been secretary of the section on General Practice of the AMA since 1951 and has served as a member of its Board of Directors.

PERSONALS

Oliver H. Nadeau, M.D., obstetrician and gynecologist, has become associated in practice with **W. Royce Hodges, M.D.,** and **L. Louis Mould, M.D.,** in Cumberland. A native of Canada, he completed his medical studies at the University of Bordeaux, Bordeaux, France. After serving his internship at Memorial Hospital, Niagara Falls, N. Y., he was resident at Union Memorial Hospital, Baltimore. Dr. Nadeau is married and has two children.

Robert D. Brodell, has been called to active duty with the U. S. Army. A captain in the 92nd Field Hospital Reserve Unit, Baltimore, he reports to Camp Gordon, Georgia. Dr. Brodell has practiced pediatrics in Cumberland since July 1960.

Frank T. Cawley, M.D., radiologist at Memorial Hospital in Cumberland, has been appointed a trustee of the Eastern Radiology Society.

Doctors L. Michael and **Gina M. Glick** announce the birth of a daughter, Celeste Michelle, on September 24 at Cumberland's Memorial Hospital.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD ROOP, M.D.

Journal Representative

In accordance with long tradition, the August meeting of the Baltimore County Medical Association took the form of a well attended crab feast.

The September meeting was held at the Penn Hotel in Towson. The guest speaker was **Mr. John Sargeant,** Executive Secretary of the Medical and Chirurgical Faculty of the State of Maryland. Mr. Sargeant chiefly discussed the relationship of the Faculty to the medical profession and to the component societies, and how the Faculty can aid the medical profession in Maryland. He discussed in some detail the Kerr-Mills Bill for providing medical care to those over sixty-five. He further spoke about physicians' defense and professional liability.

Frank Kasik, M.D., presiding at his first official meeting as president, indicated that one of his objectives is to increase membership in the County Association. He hopes to contact each member to learn of doctors who are not members.

The fact that many of our members do not belong to the American Medical Association was noted, and the desirability of their joining the American Medical Association was emphasized.

Not only is membership important, but attendance at meetings and participation in the Association's affairs are necessary for the Association to be actually representative. This problem was discussed. Suggestions were made to have an occasional social dinner meeting and to enforce the bylaw which makes attendance at two meetings a year mandatory. These and other possible solutions will be studied by the Program and Scientific Committee.

Martin Strobel, M.D., a delegate to the Medical and Chirurgical Faculty, discussed the resolutions which were acted upon at the semi-annual meeting in Ocean City.

FREDERICK COUNTY MEDICAL SOCIETY

L. R. SCHOOLMAN, M.D.

Journal Representative

The regular October meeting was held at the Francis Scott Key Hotel on October 17, the usual third Tuesday. Nothing else about the meeting was usual, however, for it was entirely social. The members were encouraged, in effect commanded, to bring their wives and were further

privileged to bring non-medical guests. The turnout was expected to be large enough to engage the ballroom. Expectations were fulfilled. The crowds and the decibel level rivaled a Washington diplomatic cocktail party.

The speaker of the evening was **Commander John Ebersole,** Medical Corps, USN, who entertained and educated us during his hour long account of the sixty-day dive of the nuclear-powered submarine USS Nautilus. His presentation was sprightly enough to keep all awake, even at that late hour.

MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.
Journal Representative

Merrill M. Cross, M.D., wrote on the "Health of the High School Athlete," an interesting article for publication in our MEDICAL BULLETIN.

Frederick Donn, M.D., spoke to the employees of a large department store on "Life Story" and to the Mothers Club of a church on "Breast Self-Examination," as part of our Medical Society's continuing program for medical information.

Carolyn Pincock, M.D., spoke to the Young Woman's Club of Gaithersburg on "Common Childhood Contagious Diseases."

A school for mentally retarded children in Montgomery County is now open at Christ Church Child Center. Non-sectarian help is available.

A rabid bat was discovered for the first time in Montgomery County. Two rabid bats were reported in other parts of Maryland several years ago.

WICOMICO COUNTY MEDICAL SOCIETY

GLADYS M. ALLEN, M.D.
Journal Representative

The Wicomico County Medical Society held its regular meeting on October 9, 1961. A report was made by **Henry Briele, M.D.,** on the progress of the tetanus toxoid immunization program.

The secretary read a memorial for **Harry M. Mattax, M.D.,** and the members of the society stood for a moment of silence in respect to his memory.

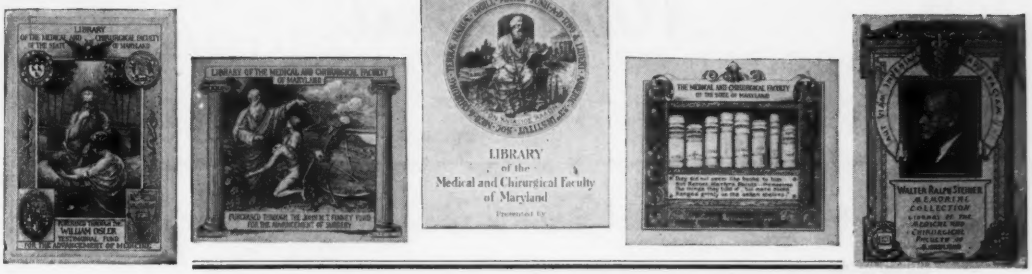
A non-medical program was presented. The first speaker was **Mr. Dale Adkins,** who clarified the relationship between the legal and medical professions. Then **Mr. Tilghman Strudwick** explained the disability and major medical insurance programs recommended by the Medical and Chirurgical Faculty of Maryland. Both speakers answered questions at the conclusion of their talks.

NEWS NOTES

William Dumire, M.D., has been appointed head of the Wicomico County Radiological Unit in the civil defense organization. **Peyton Ritchings, M.D.,** will serve as assistant director.

Charles Bagley, M.D., addressed the Parent-Teacher Association of the Wicomico Junior High School. His subject was "Parents and Students of Junior High School Age."

H. Gray Reeves, M.D., has been admitted to the American College of Surgeons.



Library

L. Robert Newburn, *Acting Librarian*

"Books shall be thy companions; bookcases and shelves,
thy pleasure-nooks and gardens." *Ibn Tibbon*

Your Library Continues To Serve You

IF YOU HAVE VISITED us recently, you have found that we are becoming increasingly well-organized, although ninety sections of books on the fourth floor and the collection of journals published before 1900 have not yet been arranged. As always, we will get for you whatever literature you need, either from our own collection or through interlibrary loan from medical libraries in Baltimore and the National Library of Medicine.

Here is the best news: Xerography has come to Med-Chi, making it possible to fulfill promptly your requests for copies of journal articles. These will be reproduced on high-quality paper which you can keep. This service is especially useful for members in the counties, who have been burdened with having to carry shipments of large bound journals from the post office, then to rewrap them and carry them back to the post office. Photocopying of articles will save time for physicians in the Baltimore area, too, and will relieve secretaries of having to trudge through rain or snow for twenty or thirty pounds of books. You may still borrow the bound journals, however, if you prefer them.

Ours is one of the few medical libraries which permits borrowing of the most recent issue of a journal. Some doctors anticipate the arrival date of a particular journal and check it out as soon as it comes in, but rarely do they keep it more than a week.

Miss Pat Cardwell joined the Library staff on July 18. She has proven most efficient in medical references, bibliographies, and the many other services of the Library. The entire staff of the Medical and Chirurgical Faculty is happy that she has joined us, and you will be, too, when you meet her.

This is your Library, and we invite your suggestions and constructive comments on how to improve it. Please bear with us in the preparation of short bibliographies; we will do each one for you as time permits for our staff of two.

The Library will remain open until 9:00 P.M. on the first Friday of each month when the Baltimore City Medical Society meets. Monday through Friday we are open from 9:00 A.M. until 5:00 P.M.

Maryland
SOCIETY OF PATHOLOGISTS INC.

EDWARD C. MCGARRY, M.D., *President* MANNING W. ALDEN, M.D., *Secretary*
Annapolis, Md.

Hospital and Insurance Control of Medical Practice: How Soon?

HOSPITALS AND THE BLUE CROSS Plans in Maryland have consistently resisted paying professional fees for pathologic services. At present, almost every hospital in the state collects the fees for pathologic services, and the pathologists are salaried employees of the hospital. Recently Blue Cross even went so far as to extend pathology coverage to hospital outpatients. The fees are to be paid to hospitals by Blue Cross even though such work constitutes service rendered by a physician. How long will it be before Blue Cross, government, or some other layman dominated agency takes over the payment of all physicians' fees?

It is an encouraging note to see action at a national level confirming the stand of the pathologists in the State of Maryland. The House of Delegates of the American Medical Association, at the Washington meeting in December 1960, considered Resolution No. 27, portions of which follow:

"WHEREAS, *Blue Cross and hospitalization insurance plans provide payment for professional services . . .*" and "WHEREAS, *Blue Cross and hospital insurance plans should provide payment for authorized hospital services only and not provide coverage for the unauthorized practice of medicine . . .*" *"Therefore, Be It Resolved that the AMA hereby expresses its renewed opposition to this practice and reaffirms its previous statements; and Be It Further Resolved, that the AMA and all state associations act with all their resources to effect immediately the transfer of professional services from Blue Cross and other hospitalization plans to Blue Shield or insurance plans providing for professional services."*

The Reference Committee report at the June 1961 AMA meeting included:

"Since this has been the policy of this Association for many years and little progress has been made in making it effective, there must be basic reasons for this lack of progress. Therefore, it is suggested that the resolution be sent to all constituent medical associations for whatever action is determined necessary to stimulate discussion of this transfer by those concerned and to ascertain the problems involved in its implementation," and *"copies . . . shall be sent to the National Association of Blue Shield Plans and the Health Insurance Council . . ."* and *"those to whom the resolution is sent be asked to report on the extent to which implementation has occurred and, if none, the reason for such inaction" . . . "it is the opinion of this Reference Committee that the solution lies in the relationship between hospitals and physicians at the local level. This Committee is in agreement with the suggestion that such implementation may lie in the practical application of policies set forth by some specialty groups and that the Council on Medical Services should meet with representatives of all groups concerned to ascertain what steps can be taken to implement the policy."*

The House of Delegates adopted the report of the Reference Committee. It is now up to your state medical society to act in accordance with these actions of the House of Delegates of the American Medical Association.

Knowing The RULES OF THE GAME

This is the first in a series of articles by the Faculty's parliamentarian. Altogether, these articles will constitute a course in the basic principles of parliamentary law. Of necessity, many details are omitted but may be found in *Robert's Rules of Order Revised*, upon which this series of articles is based. Questions may be submitted and will be answered at the conclusion of the series.

William J. Evans

FEW PEOPLE WOULD entertain the notion that they could successfully engage in a bridge game without first learning something of the rules of the game. Yet, in this country of joiners, people attend business meetings with no knowledge of the rules by which they are governed.

Those who undertake to play bridge without some knowledge of the rules may expect to lose the game. Similarly, those who try to participate in the business of deliberative assemblies with no knowledge of parliamentary procedure may expect to be frustrated. A little reflection will show that the fault very likely does not lie with a system which many generations have found best and which our forebears have been working to perfect for hundreds of years. It is no more necessary for the average member to know all about parliamentary procedure than it is necessary to know all about bridge to enjoy the game. It is necessary, though, to have some basic knowledge of the subject if a member is to be effective. His sound counsel and good ideas may be lost to the organization through his inability to present them properly.

While all rules are sometimes inconvenient, the object of parliamentary procedure is not to frustrate, but to expedite, business. It is designed to create a balance between the rights of the members and the good of the organization as a whole. Its cornerstone is the fairness and impartiality of the chair—this is the one indispensable ingredient.

The first need of a member wishing to have the attention of the meeting, either to speak in debate or to make a motion, is to *obtain the floor.* This is accomplished by rising as soon as the floor has been yielded and addressing the chair by his official title; usually, "Mr. President." If the vice-president is presiding, he is also addressed, "Mr. President." A woman is addressed, "Madam President" whether she is married or not. When two or more members seek the floor at once, everything else being equal, the member who both rose and addressed the chair first is entitled to recognition. There are certain exceptions. Generally, for example, committee chairmen are first recognized since they represent a group; and a member who has just made a motion is entitled to speak first. The chair recognizes the member by calling his name or nodding to him or indicating him in some other manner.

A member desiring to *make a motion* says: "I move that . . ." or "I move to . . ." and then states his proposal in the least words and the most direct manner. If the motion is so long that the chair will not be able to repeat it accurately, it should be submitted in writing, and the chair may

require this. A resolution is moved in this form: "I move the adoption of the following resolution: '*Resolved,* That . . . etc.,' " reading it.

Most motions should then be seconded. This is done by members calling out from their seats: "I second the motion," "I second it," or simply "Seconded." The chair should not often have to ask if there is a second because to second a motion merely means that a member is in favor of having it considered, not that he favors the motion or will vote for it.

Now, the chair must *state the question* so that everyone knows what is before the assembly for consideration. He says: "It is moved and seconded that . . .," repeating the motion, or, "It is moved and seconded that the following resolution be adopted: '*Resolved,* That . . .,' " reading it. If no one immediately seeks recognition, he adds: "Are you ready for the question?" When members desire the question put to a vote, the proper response is silence.

If the motion is a debatable one, members may now be recognized to speak. There can be no debate until a motion is stated by the chair. In debate no member may indulge in personalities or mention another member's name, although he may describe him as "the member who spoke last" or in some similar fashion. Improper motives may not be assigned to a member; the motion may be severely treated, but not its mover. The normal rule is that a member may speak once for a maximum of ten minutes and a second time for the same maximum period after everyone else who wishes to speak has had an opportunity.

After the motion has been fully considered, the chair again asks: "Are you ready for the question?" If there is no response, he *puts the question*: "The question is on the adoption of the motion that . . . (repeating it). As many as are in favor, say 'aye.' Those opposed, say 'no.' The 'ayes' (or 'noes') have it, and the motion is adopted (or rejected, or lost)." He then announces the next item of business.

NEXT MONTH

THE MOTIONS WHICH MAY BE MOVED

CALENDAR OF EVENTS

► Monday, December 18 ◄

PATHOLOGY SECTION, BCMS
8:30 P.M. Sinai Hospital

1. EXTRA-OSSEOUS PLASMACYTOMATA. Howard D. Dorfman, M.D.
2. FATAL PSEUDOMONAS INFECTION IN BURNED PATIENTS. Erwin R. Rabin, M.D.
3. HISTOCHEMICAL STUDIES OF SOME HYDROLYTIC AND OXIDATIVE ENZYMES IN NEOPLASMS OF MAN. Benito Monis, M.D.

► Saturday, December 23 ◄

MEDICINE 1961
3:30 P.M. WMAR-TV (Channel 2)
Sponsored by Baltimore City Medical Society
MY CAP IS MY CROWN. American Hospital Association Film.

► Tuesday, December 26 ◄

JOINT ANESTHESIA STUDY COMMITTEE
8:00 P.M. 1211 Cathedral Street

► Tuesday, January 2 ◄

MARYLAND SOCIETY OF ANESTHESIOLOGISTS
8:00 P.M.

► Friday, January 5 ◄

BALTIMORE CITY MEDICAL SOCIETY
8:30 P.M. 1211 Cathedral Street

► Monday, January 8 ◄

SACRED HEART HOSPITAL MEDICAL STAFF
11:30 A.M.
School of Nursing
Bellevue Street, Cumberland

► Tuesday, January 9 ◄

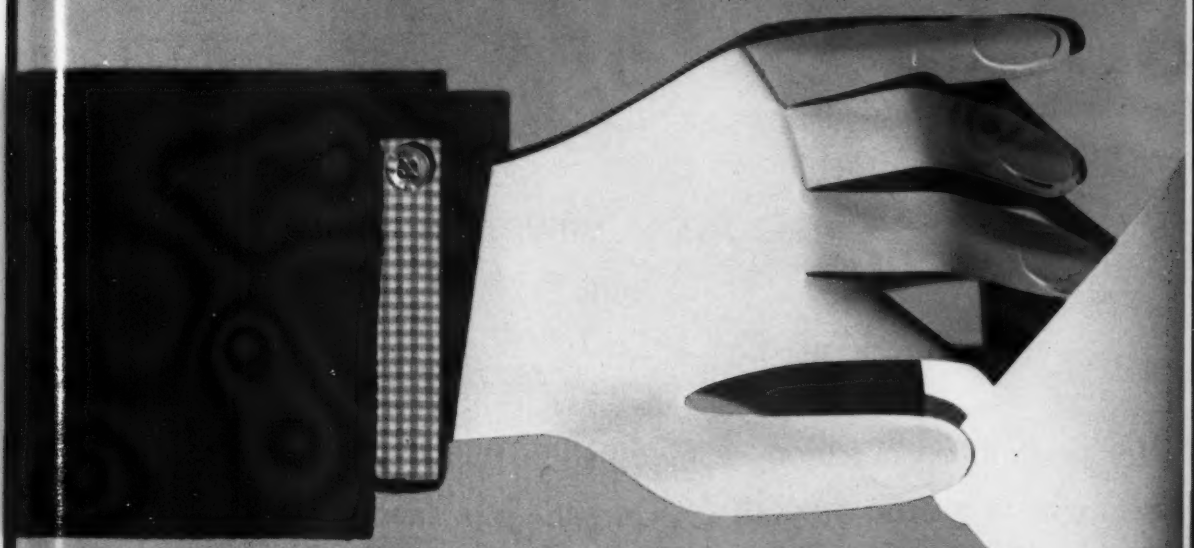
OTOLARYNGOLOGICAL SECTION, BCMS

► Wednesday, January 10 ◄

BALTIMORE CITY DENTAL SOCIETY
Sheraton Belvedere
3:00—PRINCIPALS OF OCCLUSION. Dr. Walter Cohen and Dr. Leonard Abrams
6:30—Dinner
8:00-10:00—Scientific Session

MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN
GREATER BALTIMORE CHAPTER
8:30 P.M. Coca-Cola Building
INTERPRETING DIAGNOSIS AND AIDING PARENTS IN MAKING LONG RANGE PLANS FOR THEIR MENTALLY RETARDED CHILDREN. Frederick L. Richardson, M.D.

feel the edge of this page...



Like this page, a Filmtab coating is about 1/250th of an inch thick. That's the depth of the Filmtab which seals the active ingredients into Abbott vitamin tablets.

Why do we make it paper-thin?

Filmtab coatings replace sugar coatings. This means that our vitamin tablets are quite a bit smaller than most—sometimes by as much as 30%. This makes them easier to swallow. And, because there's no bulk (not even sub-seals are needed) the nutrients are readily available. Yet, patients remain protected from vitamin odors and after-tastes.

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Filmtab coatings don't require water. Consequently, there is virtually no chance of moisture degradation. The potency your patient pays for stays in the tablet. Without sugar, we've even been able to eliminate much of the brittleness. So, tablets are less apt to chip or break.

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DAYALETS®	**OPTILETS®**	**SURBEX-T™**
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Maintenance Formulas	*Therapeutic Formulas*	*B-complex with C Formulas*

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and you'll know how thin a FILMTAB® coating can be!

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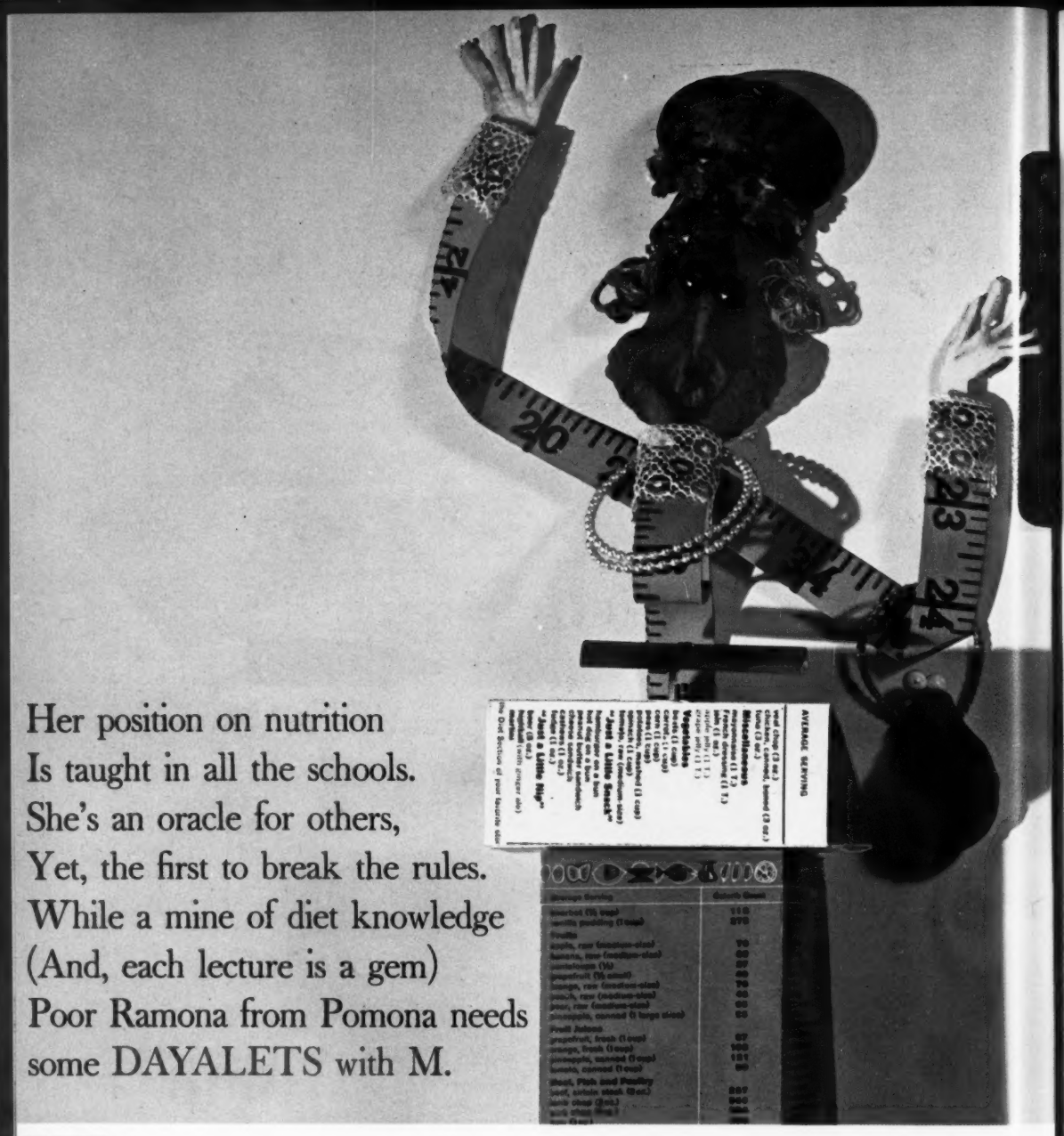

Her position on nutrition
Is taught in all the schools.
She's an oracle for others,
Yet, the first to break the rules.
While a mine of diet knowledge
(And, each lecture is a gem)
Poor Ramona from Pomona needs
some DAYALETS with M.

Likes, dislikes, and time schedules never interfere with her lectures
doctor, just her diet. She could live in a grocery store and still eat poorly. While
Dayalets-M can't replace self-discipline, it can help insure optimal nutrition
Tablets are tiny, potent, and Filmtab-coated. Patients like taking them

Filmtab® DAYALETS-M®...*essential vitamins plus 8 minerals in the most compact tablet of its kind*

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REMINDER

REGARDING

RESOLUTIONS!

IMPORTANT NOTICE
for
COMPONENT MEDICAL SOCIETIES
and INDIVIDUAL MEMBERS
of
Medical and Chirurgical Faculty

ALL resolutions or recommendations for presentation to the House of Delegates must be in the Faculty Office by WEDNESDAY, FEBRUARY 7, 1962, which is eight (8) weeks prior to the Annual Meeting, April 4, 5, 6, 1962. This is referred to in the following quote from the Faculty Bylaws:

> *". . . . A Reference Committee of five members of the House of Delegates to which all original main motions and committee reports which involve questions of Faculty policy shall be referred at least eight weeks prior to any regular and at least one week prior to any special session of the House of Delegates . . . All such main motions shall be reported to the House of Delegates with the Committee's recommendations for adoption, rejection and/or amendment, provided that with the sponsor's approval, the Committee may revise any such main motion."*

The meeting of the Reference Committee is open to all members of the Faculty in good standing, who may attend and express their opinions. Notice of the date and place of the Committee meeting will be sent to all member.

RESOLUTIONS for April 1962 House of Delegates
must be in the Faculty Office by
WEDNESDAY, FEBRUARY 7, 1962

BALTIMORE CITY HEALTH DEPARTMENT

HUNTINGTON WILLIAMS, M.D.
COMMISSIONER

P. O. Box 1877 Baltimore 3, Md. Plaza 2-2000: Extension 307

Learn To Do Your Part In The Prevention Of Disease

Radiologic Health Protection in Baltimore

Begins with Dental X-ray Machines

On July 27 the Commissioner of Health of Baltimore City received from Leon Seligman, D.D.S., president of the Baltimore City Dental Society, and A. P. Lazauskas, D.D.S., its secretary, the following resolution, adopted July 25, pertaining to a study of dental x-ray machines in Baltimore City:

WHEREAS, Radiology is an important adjunct to dental practice and the control of x-rays is essential to safe usage, and

WHEREAS, Methods have been developed to assess the output of dental x-ray machines, including beam collimation and the need for filtration under a United States Public Health Service program known as "Surpak," therefore be it

RESOLVED, That the Executive Council of the Baltimore City Dental Society invite the Baltimore City Health Department in conjunction with the United States Public Health Service to initiate this procedure (Surpak) with its membership as soon as practicable, and be it further

RESOLVED, That the dentists of Baltimore be urged to cooperate with the Commissioner of Health by participating in the program since its prime purpose is in the interest of the health and protection of the people of the city.

The City Health Department for a number of years has checked on the safety of the x-ray machines in its own chest clinics. On March 7, 1960, Mayor J. Harold Grady signed the city radiation control ordinance for Baltimore, City Ordinance No. 223. The Surpak x-ray study program was inaugurated in Baltimore City in June 1961 with the assistance of the Maryland State Department of Health and the United States Public Health Service. The first dental x-ray machines to be tested were those in the City Health Department dental clinics in the several health district buildings. Next tested were certain machines in the private offices of a number of leading dentists in the city, at their invitation, and this program is continuing.

In the Surpak program the test materials are sent to the U. S. Public Health Service for analysis. The work in Baltimore City is under the guidance of Dr. H. Berton McCauley, director of the Health Department's Bureau of Dental Care. The department is being assisted in this work by Dr. George M. Anderson, for many years chairman of the Dental Advisory Committee.

Huntington Williams, M.D.
Commissioner of Health

MARYLAND TUBERCULOSIS ASSOCIATION
Christmas Seal Agency for State of Maryland
900 ST. PAUL STREET • BALTIMORE 2, MARYLAND

AMBULATORY TREATMENT OF TUBERCULOSIS

James A. Wier, M.D., James M. Schless, M.D., Luke E. O'Connor, M.D., and Orman L. Weiser, M.D.

A GROUP OF TUBERCULOSIS patients at an Army hospital were graduated from ambulation to calisthenics to active sports without harmful results. The program was conceived to condition the patients for return to military duty.

On the basis of experience in this hospital and that of others, physical activity per se appears not to be harmful to the tuberculous process in the presence of chemotherapy.

Since an abrupt change in physical activity might occur when a patient was transferred from a status of convalescent leave to one of full military duty, it appeared appropriate to test the effect of this added physical stress in the hospital environment.

Therefore, a previous program of free ambulation was expanded to include a certain amount of controlled physical exercise in the form of calisthenics. This was gradually increased to include competitive sports and full-time on-the-job work assignments.

Purposes of Study

THERE WERE SEVERAL purposes for undertaking this study: (1) to determine if a program of active physical exercise would be harmful in patients receiving adequate multiple-drug therapy; (2) to see if it would be feasible to shorten periods of convalescent leave and time off duty by physical reconditioning during hospitalization; and (3) to see if the use of this program would further strengthen in the patient's mind the philosophy of discouraging disability attitudes, particularly in the career soldier, and encouraging the patient to think and plan constructively for the future. It is hoped that educational programs and on-the-job training can be developed to the point that the patient, from a career standpoint, would be better off for having had this period of hospitalization. If no physical harm is done, there is no question that the psychologic and morale-building advantages would be many.

All of the patients (105) had previously untreated pulmonary parenchymal disease. Daily isoniazid and PAS were given to all but those unable to tolerate PAS; as a substitute, these patients received streptomycin. The last drug was also given as an additional drug to some patients with extensive disease.

On admission to the hospital, following initial examinations and institution of chemotherapy, the patients were started on regular occupational therapy and educational programs. Asymptomatic patients were expected to participate in active calisthenics for 15 minutes per day on a five-day week basis, beginning within two to four weeks of admission; however, calisthenics were not started in some patients with far advanced disease and large cavities until two months after admission. The calisthenics were approximately on the

From Amer Rev Resp Dis, July, 1961.

level of activity given to regular troops during their basic training period. Rest periods were eliminated for these patients.

When the patients reached the noncommunicable stage, without regard to roentgenographic change, active sports were added, including basketball, volleyball, golf, bowling, and swimming. Cavities had usually been resected by this time. A minimum of one hour of active sports a day, five days a week, was required. However, most patients engaged in two hours of sports. When noncommunicable status was reached, on-the-job training was added to the program. The patient was later given a job on the post and was gainfully employed on a full eight-hour-a-day schedule for several months prior to discharge.

In 62 per cent of the patients, the disease was either moderately or far advanced; 44 per cent had cavitary disease at the time of original diagnosis; 81 per cent had tubercle bacilli in the sputum at the time of original diagnosis.

Treatment Results

THE RESULTS OF TREATMENT, as judged by roentgenographic changes, showed that 82 of the patients had either marked or moderate roentgenographic improvement; 19 had slight improvement, and four had no significant roentgenographic change. No patient showed evidence of worsening.

Of the 46 patients with cavitary disease, 20 achieved complete healing within three to eight months on chemotherapy alone. In 24 additional cases, resectional surgery for residual cavities was performed after five to eleven months of treatment. Two patients were eventually discharged with the "open-negative" syndrome. No patients with cavities were discharged if their sputum was infectious, and in no instance was there evidence of enlargement of existing cavities or development of new cavitation during the period of observation.

Of the 105 patients, 33 were subjected to thoractomy: 24 for resection of residual cavitation, five for resection of extensive residual nodular disease; in four cases, surgery was for diagnostic purposes.

Infectiousness Reversed

REVERSAL OF INFECTIOUSNESS occurred rapidly. Seventy-one of the 81 patients with tubercle bacilli in the sputum pretreatment were non-infectious by the end of the second month. Only three patients were still discharging tubercle bacilli at the end of the fourth month. One became noninfectious at the end of six months and remained so thereafter. Two patients with noninfectious sputum at the end of two months had a single culture positive for tubercle bacilli at four months, and remained negative thereafter. Both of these patients eventually came to surgery, one at six and one at ten months. A single patient continued to discharge tubercle bacilli at the end of six months. His strain of tubercle bacilli was 100 per cent resistant to isoniazid at that time. At the end of seven months resectional surgery was performed.

The average duration of hospitalization was approximately 12 months. The patients were discharged at the end of this period and advised to take additional chemotherapy for another six months, for an average of 18 months of total therapy. One hundred of the 105 patients were discharged as fit for military duty. Five were placed on temporary retirement, two for administrative reasons. Two of these patients, although unfit for military duty, were capable of living in the general community under reasonably normal conditions as their limitations were imposed by pulmonary insufficiency rather than pulmonary tuberculosis. Thus, in none of the patients was the tuberculous disease considered a disabling factor at the time of discharge.

The only harmful effects noted in the entire group were due to accidents during competitive sports—two received fractures.

STATE OF MARYLAND

DEPARTMENT OF MENTAL HYGIENE

Isadore Tuerk, M.D., Commissioner **Kurt Gorwitz, Statistics Director**

Looking Backward: 1911-1961

ALTHOUGH THE EXPRESSION, "Those were the good old days," is popularly used, few people take the trouble to determine for themselves if those "good old days" were really as good as we nostalgically like to believe.

The past fifty years have produced many profound changes in Maryland's treatment of its mentally ill. A comparison of 1911 with 1961 presents a vivid picture of the tremendous progress which has occurred during this time.

In 1911, our mental institutions were still officially called asylums. This name was a good indication of the function they performed. All had long waiting lists. Many of the mentally sick, therefore, had to be confined in county homes or were kept in private facilities, often under the most deplorable conditions imaginable. Per capita expenditure of the asylums amounted to less than $200 per annum. Patients admitted could anticipate a long period of confinement. Live discharges amounted to half of admissions, and the patient population was increasing rapidly.

In 1961, most admissions to our mental hospitals are treated and returned to the community within a short time. More than half are discharged within one year, and four out of five leave within two years. Live discharges now equal almost 90 per cent of admissions, and our hospital population is declining slowly. Per capita expenditure has increased tenfold to more than $2,000 per annum. There is no waiting list for admission to our psychiatric hospitals.

Some things do not change, however. The following quotation from the 1912 report of the Maryland Lunacy Commission is as pertinent today as it was then.

"Though much has been accomplished (in the care and treatment of the insane) in the past, it is not to be presumed that more cannot be done in the future. When we have come to the point of saying, if that time ever comes, that we are doing all we can to relieve the helpless; to promote the scientific study of psychiatry; to bring forward new and better methods of care and treatment, that time will be just the time to attempt to do more, to plan larger and better things, to prepare for better and more efficient work."

Baltimore Area Council on Alcoholism

(Successor to Maryland Society on Alcoholism)

22 East 25th Street, Baltimore 18, Maryland TU 9-3553

Care of the Alcoholic
At Private Psychiatric Hospitals
In Maryland

LICENSED PSYCHIATRIC HOSPITALS (PRIVATE), MARYLAND, 1961

Brook Lane Farm, Hagerstown. 38 beds. Mennonite Mental Health Service sponsored for acutely ill patients in need of short term hospitalization (up to 6 weeks). Costs $12 per day; psychotherapy extra.

Cedarcroft Sanitarium, Silver Spring. 50 beds. Average 7 alcoholic patients; most stay 3 months, occasionally acute alcoholics admitted. Group therapy, Alcoholics Anonymous, activity, recreational and devotional program. Costs $20 per day; physicians fees extra.

Chestnut Lodge, Rockville. 95 beds. Intensive psychoanalytically oriented psychotherapy for people who only progress in a hospital setting. Alcoholics included if this is their need. One to two years needed. Costs about $1750 monthly including psychiatric fees.

Gundry Sanitarium, Baltimore. 40 beds.

Laurel Sanitarium, Laurel. Limited to female geriatric patients with a psychotic condition.

Henry Phipps Psychiatric Clinic, Baltimore. 95 beds. Costs $23 per day; physicians fees extra.

Pinecrest Sanitarium, Baltimore.

Riggs Cottage, Ijamsville.

Seton Institute, Baltimore. 302 beds. Intensive psychotherapy and psychopharmacology. Cost $700 per month up.

Sheppard and Enoch Pratt Hospital, Towson. 265 beds. Costs $175 weekly plus physicians fees.

Sylvan Retreat, Cumberland. 90 beds. Stable geriatric problems. Treatable cases transferred to state hospitals.

Taylor Manor, Ellicott City. 97 beds. Any psychiatric problem including alcoholism may be admitted. 15 week formal program for addiction including individual and group psychotherapy, films, occupational and recreational therapy. Costs $150 weekly.

THE DEPARTMENT OF MENTAL HYGIENE of our state has licensed twelve private psychiatric hospitals. All of these were contacted regarding treatment programs for the alcoholic, and prompt answers were obtained from all but one. A catalogue of treatment programs, duration of treatment, cost, and staff was to be compiled from this information, but since seven of the eleven respondents asked specifically not to be listed in such a directory, this became impossible.

One letter said: "We do not treat alcoholics as such. Under no circumstances will we admit an alcoholic for 'drying out' or for short periods. All patients of all kinds must be referred by physicians. When the referring physician is able to suggest a more than reasonable likelihood that the patient is suffering from a basic or primary psychiatric disorder, we may then admit such a patient for long term treatment of the psychiatric disorder in the belief that if our treatment is successful, the alcoholism or addiction may take care of itself." This respondent adequately worded a view that six of the eleven letters carried. It is to be emphasized that no hospital refused admission to alcoholics but that most hospitals required the alcoholism to be a symptom of a psychiatric disorder which they were qualified to treat. All seven of the hospitals asking not to be listed in a directory on alcoholism have alcoholics among their patients; they prefer that their reputation be built on other areas of mental hygiene.

Six of the letters noted that patients suffering from acute alcoholism needed to be treated in general hospitals. Five of these six had accepted patients with alcoholism in transfer from general hospitals when it had been determined that a longer course of therapy seemed indicated and desirable.

Four hospitals commented on the treatment of alcoholics. The shortest time of treatment recommended was four weeks for the non-psychotic acute alcoholic; another recommended fifteen weeks. Two others needed six months to one year for the therapy of alcoholism.

CONCLUSIONS: As a group the private psychiatric hospitals of our state do not actively participate in the treatment of the non-psychotic alcoholic, largely because of the poor motivation of this group for treatment and the poor success rate. Treatment of the acute alcoholic, whether or not he is psychotic, is difficult, and no medical institution actively solicits this work. The private psychiatric hospitals share this view. In general, programs aimed at the rehabilitation of the alcoholic are available to only a small number of patients in a very few hospitals. Treatment programs in private hospitals are similar to those available in the state hospitals. I believe that the private hospitals, even those that accept alcoholics, do not actively solicit this work.

It seems now that the excellent state hospital programs such as that at Spring Grove and Crownsville are to be recommended to some of our private patients. Expansion of these programs seems more easily attainable than expansion of the beds open to alcoholics in the private hospitals.

Frank L. Iber, M.D.

RETARDED CHILDREN CAN BE HELPED

MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN

Greater Baltimore Chapter, Inc.

2434 Greenmount Avenue Baltimore 18, Maryland TUxedo 9-5410

President
MRS. WILBUR P. ULLE

Editor
JOAN B. SOBEL

Parent Counseling for the Retarded

Clara Ann Hochreiter

MR. AND MRS. T. were informed by their pediatrician that their two-month-old son was "mentally retarded." "Mongoloid" was the term the doctor used as he pointed out various physical stigmata, and he predicted that the parents might expect some "brain" difficulty in the future. Mr. T. had heard the term "mongoloid" before, but he could not recall in what context, so he just numbly nodded his head. His wife, on the other hand, heard "drain" instead of "brain"; so, completely ignoring all implication of mental retardation, she proceeded to concentrate on the physical problems to be anticipated due to the child's peculiar nose structure.

Beyond this point the pediatrician's interpretation fell upon unhearing ears, but fortunately for the parents, he pressed into their hands a folder describing the services of the Maryland Society for Mentally Retarded Children, Greater Baltimore Chapter, with the suggestion that they would probably find this parent group helpful in many ways.

After several days of pondering the doctor's statements, the parents called our office with many questions, some relating to present care, others relating to future planning. What does "retarded" mean? Will he ever marry? How far will he go in school? Shall we keep him at home or place him in an institution? What shall we tell our neighbors and relatives?

Upon receiving parent inquiries such as these, we arrange to have a trained social worker visit the home at a time when she can talk with both parents. The promptness of her response to their appeal and the warmth of her acceptance of their problem set the stage for their faith in the organization she represents. She assures them that their experience is not isolated or unique. Many parents like them have faced the situation and found a compromising solution to a similar challenge.

Brochures describing the services of the Maryland Society for Mentally Retarded Children, Greater Baltimore Chapter, are available in any quantity to physicians requesting them.

Rather than telling them what to do, the social worker indicates several possibilities of choice, helping them to focus on the broad needs of the total family group in their planning. Her reservoir of knowledge regarding community resources is available to them, and as the years progress, she guides the parents in the wise selection of those services which meet the changing needs of the child. The range of these services include a cooperative nursery group, special classes in public and private schools, residential care, diagnostic and evaluation clinical services, day and residential camps, recreational programs, and occupational training.

Through the social worker, the parents are in-

*Mrs. Hochreiter, a psychiatric social worker, is one of a group of highly trained professionals employed by the Maryland Society for Mentally Retarded Children, G.B.C., Inc., to aid both parents of retarded children and the professional people working with the mentally handicapped. Mrs. Hochreiter, who has been with the Society for more than five years, is also on the faculty of the College of Notre Dame of Maryland. Previously she worked for many years with guidance clinics and has held appointments on a number of university faculties.

troduced to various types of reading material and to members of The Maryland Society for Mentally Retarded Children, Greater Baltimore Chapter. Through identification with this group, the parents learn to plan and work together for all retarded people. What was originally a self-centered preoccupation with their own individual problem gradually expands into a genuine concern for the entire community of the retarded. Parents teach parents by example, and individual anxiety is replaced by confidence as they discover that they can find their own solutions to new crises as they arise.

DOCTOR DIPLOMATS

Five physicians from Tulsa, Oklahoma, members of the First Presbyterian Church of Tulsa, are giving up their practices for six-week periods to serve voluntarily at the Miraj Medical Center in Miraj, India. The first of the group of volunteer physicians flew to Miraj in mid-August and returned at the end of September; then the second doctor departed. In all, the five physicians will donate a total of thirty weeks to the program.

The project is endorsed by the Tulsa County Medical Society. Funds for medical equipment, transportation and other expenses were raised through church and public contributions. C. S. Lewis, M.D., one of these five Tulsa physicians, recently reported to the AMA on the progress of the project labeled "Doctors in Asia."

Other groups of American physicians are also becoming interested in initiating a similar venture in their own communities. Several doctors met with Doctor Lewis during his AMA visit to discuss the feasibility of adopting an overseas program which would provide medical care to another area of the world equally in need of such assistance.

The interest and willingness of American physicians to serve in foreign mission fields on a temporary basis is shown by the large number of doctors who have written to the AMA Department of International Health in the last few months to inquire about such service. This new Department administers a program, approved last June by the AMA House of Delegates, whereby members of the AMA may volunteer for temporary service in the foreign mission fields when emergencies arise. Cooperating with AMA in this program are missionary agencies representing every religious denomination sponsoring American medical missionaries.

Physicians interested in volunteering for such service are asked to write directly to the AMA Department of International Health, 535 N. Dearborn Street, Chicago 10, Illinois.

The Heart Page

J. Michael Criley, M.D.—*Editor*

A SERVICE OF
THE HEART ASSOCIATION OF MARYLAND

The Bedside Diagnosis of

PAROXYSMAL VENTRICULAR TACHYCARDIA

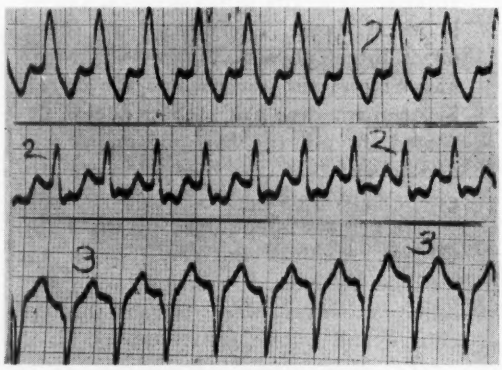
Neil Schwartz, M.B. (RAND) M.R.C.P.

THE ELECTROCARDIOGRAM is not always the final arbiter in the differential diagnosis of rapid arrhythmias. For the diagnosis of ventricular tachycardia it is often not only inferior to the physical signs, but may be dangerously misleading.

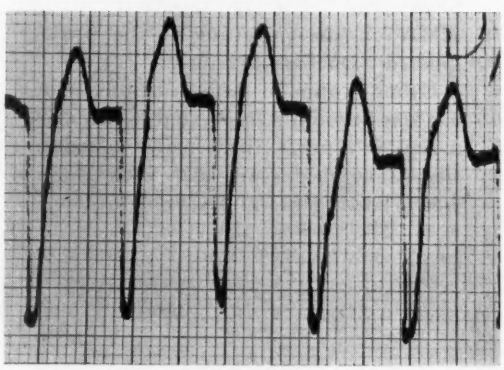
The reason for this anomaly lies in the unpredictable behavior of the conducting system of the ventricular myocardium when subjected to a flow of impulses at two, three, or four times the normal rate. In an old or diseased heart, this may easily result in failure of one or other bundle branch or their terminal fibers to conduct at a normal rate or even at all. Consequently, wide, bizarre QRS complexes are formed which may easily be misdiagnosed as ventricular in origin.

Alternatively, bundle branch block may exist prior to the tachycardia, and if this is not known to the physician, the wide QRS complex seen with tachycardia may lead to the erroneous diagnosis of ventricular tachycardia. Figure 1 illustrates such a case. Proof that the tachycardia was supraventricular in origin is provided by the EKG in Figure 2, taken a few hours after the tachycardia subsided. The same bizarre QRS complexes may be seen, each now preceded by a sinus P wave and clearly due to bundle branch block.

Figure 1
EKG showing rapid ventricular rate, wide QRS complexes and no visible P waves.



a. Standard limb leads I, II, III.



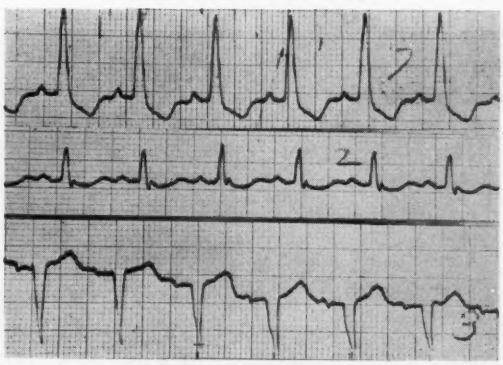
b. Lead V-1.

Thus, ventricular tachycardia may be mimicked electrocardiographically by any rapid rhythm of supraventricular origin, including atrial flutter or atrial fibrillation with rapid ventricular response, provided either that bundle branch block pre-existed or that aberrant intraventricular conduction results from the rapid rate.

Most ventricular tachycardias, in contrast to supraventricular arrhythmias, produce A-V dissociation, since the atria remain under sinus control and continue to beat at a far slower rate than the ventricles. With one exception, to be dealt with later, it is the A-V dissociation and not the tachycardia per se which lends itself to diagnosis, either electrocardiographically or clinically. In the rare instances when a nodal tachycardia with wide QRS complexes co-exists with retrograde block to the atria, and hence A-V dissociation, there are no means whatsoever of distinguishing the two conditions other than by inference.

Figure 2

The same wide QRS complexes are seen at a slower rate, each preceded by a sinus P wave.



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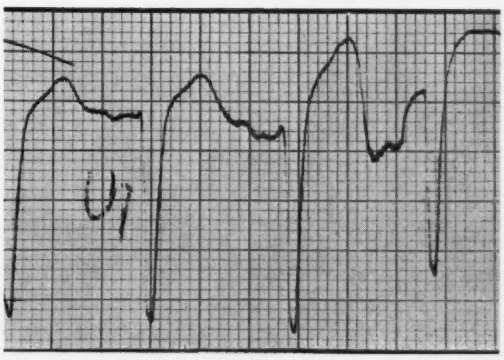

b. Lead V-1.

Thus, ventricular tachycardia is recognized by the A-V dissociation it causes. Hence, if regular P waves can be seen at a slower rate superimposed on the QRS complexes, then ventricular tachycardia is the likely diagnosis. If the atria occasionally "capture" the ventricles, producing a slightly early QRS complex of more normal contour and duration, then ventricular tachycardia may be diagnosed with absolute certainty; this is the exception mentioned previously. Unfortunately, this is a relatively rare event and will take place only with the slower tachycardias.

Bedside diagnosis of ventricular tachycardia depends also on A-V dissociation. Independence of atrial and ventricular contraction results in variation of the P-R distance, and hence a variable relationship between ventricular contraction and the position of the A-V valves. This produces two classical and easily recognized physical signs. The longer the P-R distance, the softer the first heart sound, and vice versa. Consequently, the varying P-R distance causes a variation in intensity of the first heart sound, best heard at the apex with the patient holding his breath to exclude respiratory variation. The second sign is the occurrence in the neck of a cannon wave, an abrupt, forceful wave caused by the force of atrial systole being expended against a closed tricuspid valve and hence regurgitating atrial content into the veins. Naturally, these cannon waves will occur irregularly and at a rate slower than the ventricular rate, depending as they do on the intermittent coincidence of atrial and ventricular systole. Thus, by listening to the first heart sound for fifteen or twenty seconds and observing the internal jugular veins for a similar period, the clinical diagnosis of ventricular tachycardia may be made in most instances. However, should the retrograde block be incomplete or absent, resulting in activation of the atria at the same or one-half the ventricular rate, than no routine method of examination will distinguish ventricular tachycardia from nodal tachycardia with bundle branch block, as the first heart sound will be constant and cannon waves will be regular in each instance.

In contrast to the above situation, in atrial tachycardia there are no cannon waves, and the first heart sound will be constant, whereas in A-V nodal tachycardia there is a constant first heart

	Cannon Waves	Constant 1st Heart Sound
Ventricular tachycardia	Irregular, slower than ventricles	Absent
Nodal tachycardia	Regular, same rate as ventricles	Present
Atrial tachycardia	None	Present
Atrial flutter	Regular, faster than ventricles	Present
Atrial fibrillation	Absent	Absent

sound, but cannon waves occur with every beat as the atria are activated retrogradely and hence always contract during ventricular systole. Atrial flutter will result in regular cannon waves at two, three or four times the ventricular rate. Finally, atrial fibrillation will result in rapid, *irregular* heart rate with varying intensity of the first heart sound but with no cannon waves. These differences are summarized in the accompanying table.

Finally, the usual maneuvers used to break a supraventricular tachycardia, such as eyeball or carotid sinus pressure, should always be applied in a doubtful case. The cessation of a tachycardia under these circumstances precludes the diagnosis of ventricular paroxysmal tachycardia.

Careful attention to physical signs will result in a high degree of accurate diagnosis with much benefit to the patient.

Woman's Auxiliary

MRS. WILLIAM S. STONE, *Auxiliary Editor*

December 1961

OFFICERS AND COMMITTEE CHAIRMEN OF THE WOMAN'S AUXILIARY TO THE ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

President: Mrs. Howard L. Tolson
Vice President: Mrs. Carlton Brinsfield
Treasurer: Mrs. William P. Iames
Secretary: Mrs. R. Rhett Rathbone
Future Nurses Committee: Mrs. A. J. Mirkin
Public Medical Education: Mrs. Carlton Brinsfield
Civil Defense: Mrs. Leland B. Ransom
Program: Mrs. Leslie R. Miles
Social Committee: Mrs. Robert D. Brodell
AMEF: Mrs. Thomas F. Lewis

Introducing Our County Presidents

Mrs. Howard L. Tolson, President
Woman's Auxiliary to the
Allegany-Garrett County Medical Society

ALLEGANY-GARRETT COUNTY Auxiliary's president is a Wisconsin-born nurse. Mrs. Howard L. Tolson, as an undergraduate at the University of Wisconsin, majored in sociology. She received her Bachelor of Science degree in 1928 and continued her education at the University of Wisconsin School of Nursing, where she was awarded an R.N. in 1930. In 1959 she completed studies for a degree of Master of Arts from Columbia University.

In the intervening years, after her graduation from the University of Wisconsin, Mrs. Tolson was educational director at Ashland General Hospital School of Nursing, Ashland, Wisconsin. She moved to Fairmont, West Virginia, to become educational director at the Cook Hospital School of Nursing. In 1935 she moved again, this time to Cumberland, Maryland, where she was educational director at the Memorial Hospital School of Nursing. This was a significant move, for it led to her becoming the wife of Howard L. Tolson, M.D., and her temporary retirement from her career.

During World War II, however, she resumed her position at Memorial Hospital. In 1948 she resigned again to become nurse consultant and instructor at Frostburg State Teachers College, a position which she held for nine years.

Among her past activities, Mrs. Tolson was an organizer and the first president of Susan Cook District of the West Virginia State Nurses Association and of District Number I, Maryland State Division of American Nurses Association. She helped to organize the Memorial Hospital Auxiliary and is a past president. During World War II she was nurse recruitment chairman for Allegany and Garrett Counties.

In addition to being president of the Allegany-Garrett County Auxiliary, Mrs. Tolson is president of the Cumberland Branch, American Association of University Women. Her hobbies are music, art, sailing, and skiing.

The Allegany-Garrett County Auxiliary has planned a well rounded program this year, with meetings devoted to AMEF, legislation, medical ethics for doctors' wives, and Doctor's Day, as well as a tea for the members of the Future Nurses

MARYLAND
STATE MEDICAL JOURNAL

official monthly publication of
THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
1211 Cathedral Street, Baltimore 1, Maryland

Volume 10 December 1961 Number 12

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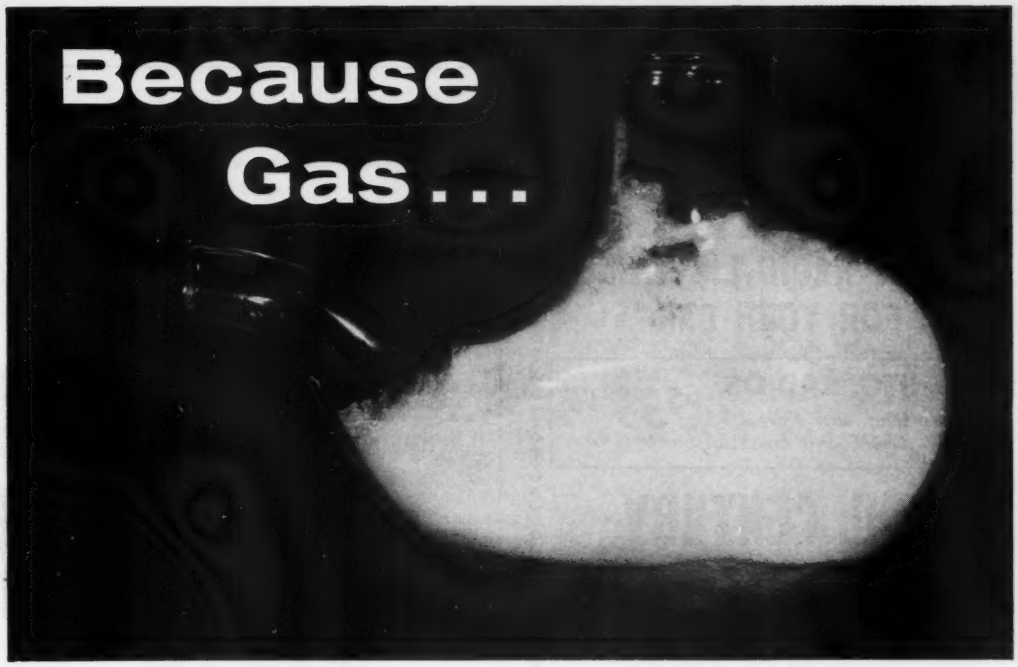

often accompanies hyperacidity...

NEW SILAIN-GEL[T.M.] LIQUID TABLETS

DEFROTHICANT • ANTACID

should be part of antacid regimens

When peptic ulcer, hyperacidity and heartburn are complicated by gas, they require more than antacids . . . *they require Silain-Gel!*

Silain-Gel includes a defrothicant, methylpolysiloxane*, that breaks up frothy bubbles thus liberating gas for elimination. And Silain-Gel includes the properly balanced antacid formulation for maximum neutralization.

Patient acceptance is assured by the non-fatiguing fruit mint taste of Silain-Gel. Silain-Gel is safe for long-term administration.

Dosage: Silain-Gel Liquid—2 teaspoonfuls 4 times daily after or between meals and at bedtime. Silain-Gel Tablets—2 tablets (chewed or swallowed) after meals and at bedtime.

Formula: Each tablet contains 25 mg. activated methylpolysiloxane, 282 mg. aluminum hydroxide (equivalent to Dried Gel, U.S.P.) and 85 mg. magnesium hydroxide. Each teaspoonful of Liquid is equivalent to 1 tablet.

Available: Silain-Gel Liquid—Plastic Flask, 12 fl. oz.; Silain-Gel Tablets—Bottles of 100.

Write for Clinical Trial Supply and Detailed Literature.

*U.S. Patent No. 2,951,011

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THE TIME AND PLACE

Sally Ladin Ogden

December is a wonderful month—we hardly notice the shortness of the days and the fact that we are still at our desks when darkness comes. Maybe it's because we are looking forward to the holidays, the excitement of shopping and the social season ahead.

The SUBURBAN CLUB BEVERAGE COMPANY, INC. of Baltimore located at 1808 N. Patterson Park Avenue adds an appealing touch to any party with its fine selection of non-alcoholic beverages regardless of the season.

The firm was organized in 1921 with a general line of carbonated beverage flavors. It became the first Pepsi-Cola bottler under the present operation of the Pepsi-Cola Company in the early Thirties.

The Corporation officers are Mr. Abe Lapides, President; Messrs. Ben and Morton Lapides, Vice Presidents; and Mr. Joseph Lapides, Secretary-Treasurer, who are all civic leaders and are well known for their charitable endeavors.

The firm, over the years, has continued to grow and expand its Suburban Club line, and in 1956 because of the demand for sugar-free products, the management decided to begin marketing a new drink—Slim Line. This particular beverage, coming at a time when most people are watching their caloric intake, has become a very popular drink.

Slim-Line is sold in classic style, non returnable sixteen ounce bottles. Slim-Line flavors include Pale Dry Ginger, Golden Ginger, Orange, Black Cherry and Root Beer.

The SUBURBAN CLUB BEVERAGE COMPANY has been in business for over forty years and has operated from its two locations since 1942. Pepsi-Cola and associated products are bottled and distributed from their plant at 400 Key Highway. The Suburban Club flavors, Squirt, Schweppes, Quinine Water and Slim-Line are sold by the driver-salesmen whose trucks operate out of the 1808 North Patterson Park Avenue plant.

* * * * *

All during the year Savings and Loan firms keep reminding us that Christmas and the holidays will be more cheerful if we prepare for them through Savings Accounts.

Three such firms have excellent backgrounds in this field. They have held to high, safe dividends, and their management and reputations rank among the best.

FRATERNITY FEDERAL SAVINGS AND LOAN ASSOCIATION was organized by a small group of men in 1913. Its assets at that time were approximately $16,000.00. Today all of us are conscious of the necessity of a savings account, not only for Christmas but for building or remodeling homes, our children's education, or retirement. We look to firms like FRATERNITY FEDERAL SAVINGS AND LOAN ASSOCIATION,

which now has assets of approximately $32,000,000.00. FRATERNITY FEDERAL SAVINGS AND LOAN ASSOCIATION was originally called the Fraternity Building and Loan Association. The Federal Savings and Loan Insurance Corporation was set up by Congress in 1934. In 1936 FRATERNITY FEDERAL SAVINGS AND LOAN ASSOCIATION made application for a Federal charter and membership in the Federal Savings and Loan Insurance Corporation, which it received, and at that time its name was changed to the present one.

The Association has always operated offices in the general location of the 700 block of Washington Blvd. Its present office was built in 1949 by the association and was three times enlarged, until now it occupies a quarter of the 700 block of Washington Blvd.

There are three drive-in windows and a large parking lot at the rear of the building to accommodate customers.

The officers of FRATERNITY FEDERAL SAVINGS AND LOAN ASSOCIATION are Thomas J. Stoddard, President; Mrs. Anna Mackin, Vice President; Charles J. Spielman, Vice President and Treasurer; and William C. Rogers, Sr. and William C. Rogers, Jr. are co-Attorneys for the Association.

The firm recently opened a branch office in Howard County in the Normandy Shopping Center: Baltimore National Pike (Route 40) near Rogers Ave., Ellicott City, Maryland.

* * * * *

Plans for the new building of VERMONT FEDERAL SAVINGS AND LOAN ASSOCIATION in the Charles Center are in process and construction is expected to start in 1962, according to George J. Roth, the association's executive vice president.

The new building will be of contemporary design, and will be erected at Vermont Federal's present location at Fayette and Hanover.

Totalling over 50,000 square feet, the proposed structure will have a basement and five floors above ground. Besides a walk-way at street level, there will be an elevated walk at the second floor.

Both will be covered, with the top floors projecting over the two lower stories.

Present plans also call for a walk-up teller's window, escalators between the first and second floors, and air-conditioning throughout.

The projected structure will face a landscaped mall to the north, under which Charles Center plans call for a parking garage with a capacity of approximately 800 cars.

The architect for VERMONT FEDERAL'S new building is Edward Q. Rogers, and tentative plans indicate that it will be completed during 1963.

Organized nearly 40 years ago as a neighborhood association, VERMONT FEDERAL now has savings accounts from all over the United States and in some foreign countries.

The association qualified for Federal Savings and Loan Insurance in 1937, and received its federal charter on Feb. 24, 1939.

In 1951, VERMONT FEDERAL moved to its present downtown location at Fayette and Hanover, bought the building there in 1955, and in 1959 completely remodeled its offices and the first floor.

When the association moved down from its neighborhood location, assets were $6,618,000.00. Since then, VER-

MONT FEDERAL has more than quadrupled in size, with assets now totaling over $30,000,000.00.

Of the present directors, five were members of the original board when the association was founded in 1922. They are Philip J. Hauswald, president; William C. Rogers, attorney; Carl C. Hauswald, Timothy J. Dee and Frank J. Vierengel, treasurer.

Other members of VERMONT FEDERAL'S board are George J. Roth, executive vice president; William M. Dee, secretary; Frederick J. Wiedeck; Luke K. Burns, Philip J. Hauswald Jr., William C. Rogers Jr., attorney, and John Hauswald.

John E. Fish is assistant vice president, and James C. Lockard and Joseph J. Turek are assistant secretaries. John S. Grasser is assistant treasurer.

In May of this year, VERMONT FEDERAL opened a branch office in the Northwood Shopping Center, and Thomas E. O'Neill, Jr., was appointed supervisor of branch operations.

* * * * *

The ARUNDEL FEDERAL SAVINGS AND LOAN ASSOCIATION has a unique history.

In September, 1906, a small group of citizens and local businessmen of Brooklyn, interested in helping to make it possible for the people of Brooklyn to buy their homes and have them financed, organized the Arundel Perpetual Building and Loan Association. This new organization was first located in a corner of a lumber company's storeroom at Sixth Street and Patapsco Avenue.

After a few years, the Association moved to a small building just four doors west of its original location and during the next twenty years accumulated enough surplus to purchase a permanent site. The organization moved into a new building at 419 Patapsco Avenue in September of 1934. By 1935, a Federal charter was adopted, and the name changed to the ARUNDEL FEDERAL SAVINGS AND LOAN ASSOCIATION.

By 1951, business had grown so that larger, more modern quarters were needed. Plans were made to erect a Williamsburg type building on the corner of Patapsco Avenue and Fourth Street. In addition, these plans included a community hall in the basement with all the necessary facilities for any community activities and four professional offices on the second floor.

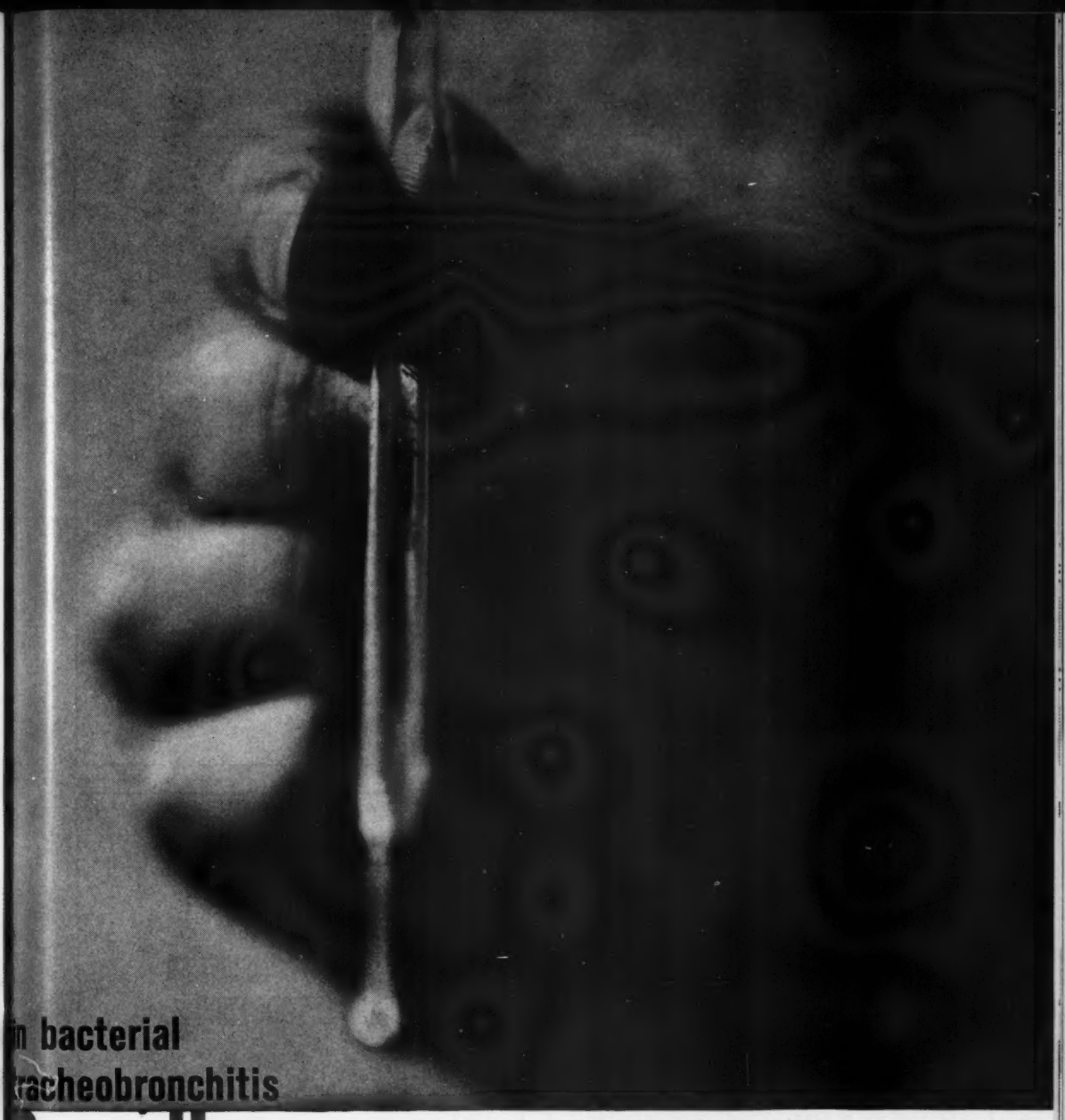
This modern building, completed in September of 1951, has the finest facilities for its purposes south of the Patapsco River in the state of Maryland. Here it is possible to render the finest service to the friends of ARUNDEL FEDERAL SAVINGS AND LOAN ASSOCIATION.

When the firm moved into its quarters in 1935 it had assets of $8,487,000.00; today its assets are in excess of $21,000,000.00.

The officers of ARUNDEL FEDERAL SAVINGS AND LOAN ASSOCIATION are John P. Helmer, President; M. Richmond Farring, Exec. Vice-President; John McGregor, Vice-President; Henry C. Bourke, Jr., Treasurer; Victor A. Pyles, Jr., Asst. Treasurer; E. Jane Rusinek, Secretary; Inez A. Brown, Asst. Secretary and E. Raymond Miller, Jr., Controller.

At ARUNDEL FEDERAL SAVINGS AND LOAN ASSOCIATION you will find a friendly group—ready to help with any Savings or Loan problem.

The management looks forward to serving you.



in bacterial tracheobronchitis

Panalba* promptly

to gain precious therapeutic hours

In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical in terms of the time and facilities available.

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Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

Panalba — your broad-spectrum antibiotic of first resort

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.
Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, a few cases of leukopenia and thrombocytopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

*Trademark, Reg. U.S. Pat. Off.
The Upjohn Company
Kalamazoo, Michigan

Upjohn

EXECUTIVE SECRETARY'S NEWSLETTER

December, 1961

1962 DUES BILLS

1962 dues bills for all members have been placed in the mail and should be taken care of by all members so that payments are received in the Faculty office BEFORE JANUARY 31, 1962. The Bylaws require that a physician is not entitled to legal defense if his dues are not paid before this deadline.

If you have not received your bill, contact the Faculty office so that a duplicate may be mailed.

ANNUAL MEETING

In setting up your 1962 calendar be sure to take note of the dates of the annual meeting:

Wednesday AM, April 4 - House of Delegates
Wednesday PM, April 4 - Scientific Sessions
Thursday, all day, April 5 - Scientific Sessions
Thursday Evening, April 5 - Annual Dinner
Friday AM, April 6 - Scientific Sessions
Friday PM, April 6 - House of Delegates

RESOLUTIONS FOR ANNUAL MEETING

Any individual or component medical society may present a resolution for consideration by the Faculty's House of Delegates at the annual meeting.

Resolutions must be received in the Faculty Office BEFORE WEDNESDAY, FEBRUARY 7, 1962, in order to be considered at this House meeting. This is in accordance with the Faculty's Bylaws.

MEDICARE PROGRAM AMENDMENT

Immunizations, parenterally administered against Poliomyelitis and Influenza are authorized benefits under the Dependents' Medical Care Program operated for members of the U. S. Armed Forces. Claims, etc., are handled in the usual manner. It is pointed out, however, that the physician is only reimbursed for the cost of the vaccines used as the professional services are considered part of the complete maternity care payment.

PERSONALITIES

James O'Hare, M.D., is now associated with the Travis Clinic, Jacksonville, Texas.

Peter Rodman, M.D., Harford County, is the new president of the Harford County Heart Association.

PERSONALITIES (cont'd)

Abraham A. Silver, M.D., Baltimore, has been reappointed Governor for the State of Maryland on the American Diabetes Association's Board. His term is from 1961 - 1964.

Jacob H. Conn, M.D., has received the 1961 Bernard B. Raginsky, M.D., Award at the 13th annual meeting of the Society for Clinical and Experimental Hypnosis.

Jesse C. Coggins, M.D., advises that Laurel Sanitarium has been accepted for listing in the Guide Issue of Hospitals, Journal of the American Hospital Association.

NEWS NOTES

Manning W. Alden, M.D., Annapolis, has been elected president of the Maryland Society of Pathologists.

William A. Williams, M.D., Annapolis, has been elected Secretary of the same group.

Elected to membership in the American Society of Anesthesiology are:

John P. Noury, M.D., Bethesda
Robert A. Abraham, M.D., Lutherville
Daniel B. Harris, M.D., Baltimore

NEW COMPENSATION FEE SCHEDULE

The newly approved Workmen's Compensation Fee Schedule has now been published. Copies may be obtained by contacting the Workmen's Compensation Commission, Rm. 501, 108 East Lexington Street, Baltimore 2, Maryland.

The Faculty Office does not have copies available for distribution.

The adoption of this schedule and its publication marks the culmination of many months work on the part of the Faculty's Fee Schedule Committee.

VISITS TO COMPONENTS

The Executive Secretary has visited many component societies during the past few weeks. A partial list includes visits to Cecil, Harford, Anne Arundel, Washington, Prince George's and Montgomery Counties.

This marks the third year for regular, annual visits to components to acquaint them with activities of the Faculty on a statewide basis.

John Sargeant
Executive Secretary

In oral penicillin therapy

COMPOCILLIN-VK

offers the speed, the certainty,

the effectiveness

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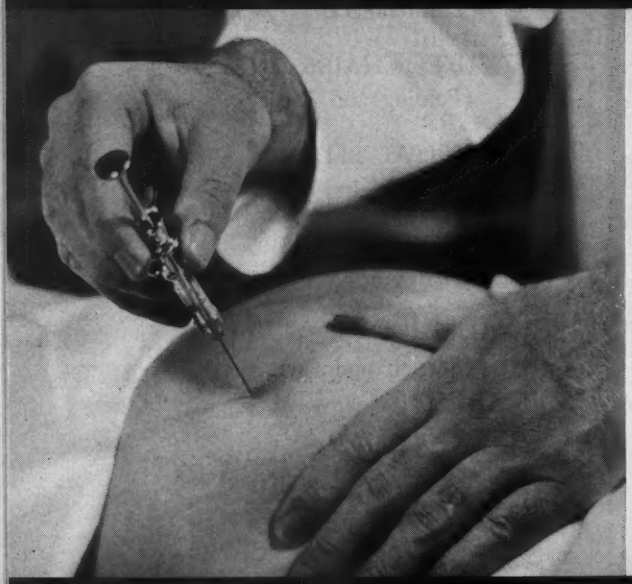

with the safety

and the convenience

of this...

IN ORAL PENICILLIN THERAPY

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POTASSIUM PENICILLIN V

BECAUSE potassium penicillin V (Compocillin-VK) offers excellent absorption[1,2,3,4]—fast, predictable levels of antibacterial activity enter the blood stream and quickly reach the site of infection. *Absorption takes place high in the digestive tract and is virtually unaffected by gastric media.*

Antibacterial levels are so predictable that, in many cases, *Compocillin-VK may be prescribed in place of injectable penicillin.* This is especially appreciated by younger patients and—as you know—oral administration is considered far safer than injectable.

Compocillin-VK is well tolerated and may be used in treating mild, severe, and in high dosage ranges, even critical cases involving penicillin-sensitive organisms. It comes in stable, palatable forms for every patient—every age.

There are tiny, easy-to-swallow Filmtab® tablets—125 mg. and 250 mg. (200,000 units and 400,000 units), a tasty, cherry-flavored suspension (each 5-ml. teaspoonful contains 125 mg.) and two combinations (Filmtab and suspension) with the triple sulfas. Depending on severity of infection, dosage for Compocillin-VK is usually 125 mg. or 250 mg. three times a day. Won't you try Compocillin-VK?

1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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B COMPLEX WITH VITAMIN C

Improved Formula

Thiamin Chloride	B_1	10 mg.	Ascorbic Acid	C	150 mg.
Riboflavin	B_2	10 mg.	Calcium Pantothenate		20 mg.
Pyridoxine HCL.	B_6	5 mg.	Niacinamide		50 mg.
Cyanocobalamin	B_{12}	4 mcg.			

BETA MASSIVE FORTIFIED WITH B_{12} AND VITAMIN C

WHERE A MASSIVE DOSE OF WATER SOLUBLE VITAMINS IS INDICATED

Contains No Folic Acid

"One reason for raising vitamin concentrations to supra-physiologic levels: the belief that very large doses of a drug may exert a 'mass effect' capable of turning the tide of a progressing pathologic condition when smaller doses would fail."

(H. Molitor and G. A. Emerson, volume 6 of Vitamins and Hormones.)

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

Introduced to the patient through the physician only—

LOWER IN PRICE

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PABALATE®

mutually potentiating nonsteroid antirheumatics

"superior to aspirin"[2] and with a "higher therapeutic index"[1]

In each yellow enteric-coated PABALATE *tablet:*

Sodium salicylate (5 gr.) 0.3 Gm.
Sodium para-aminobenzoate (5 gr.) 0.3 Gm.
Ascorbic acid.....50.0 mg.

When sodium should be avoided—

PABALATE®-SODIUM FREE

In each pink enteric-coated PABALATE-SODIUM FREE *tablet:*

Same formula as PABALATE, with sodium salts replaced by potassium salts.

When conservative steroid therapy is indicated—

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Pabalate with Hydrocortisone

In each light blue enteric-coated PABALATE-HC *tablet:*

Same formula as PABALATE-SODIUM FREE, plus hydrocortisone (alcohol) . . . 2.5 mg.

1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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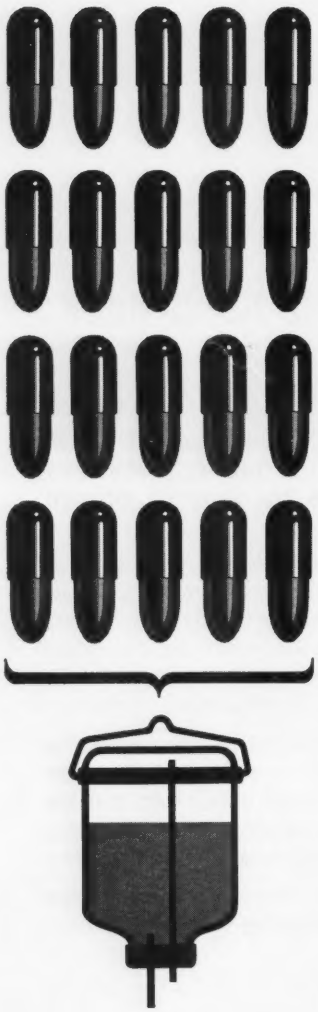
Making today's medicines with integrity...seeking tomorrow's with persistence.



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■ See
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TRINSICON®

(hematinic concentrate with intrinsic factor, Lilly)

For a rapid hematological response
. . . striking clinical improvement

Two Pulvules® Trinsicon daily are capable of producing in ten days an Hb and RBC response comparable to that obtained after a transfusion of one pint of whole blood. For potent, complete anemia therapy, prescribe Trinsicon.

Two Pulvules Trinsicon (daily dose) provide:

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor) . . . . 300 mg.

Vitamin B_{12} with Intrinsic Factor Concentrate, N.F. . . . . 1 N.F. unit (oral)*

Cobalamin Concentrate, N.F., equivalent to Cobalamin . . . . . 15 mcg.†

(The above three ingredients are clinically equivalent to 1½ N.F. units of APA potency.)

Iron, Elemental . . . . . 220 mg. (as Ferrous Sulfate)

Ascorbic Acid (Vitamin C) . . . . . 150 mg.

Folic Acid . . . . . 2 mg.

*Potency established prior to mixture with other ingredients.

†Obtained from extractives of suitable microbial organisms and liver and determined microbiologically against vitamin B_{12} standard; the total amount, including that contained in the Vitamin B_{12} with Intrinsic Factor Concentrate, N.F., is 30 micrograms.

Product brochure available;
write Eli Lilly and Company, Indianapolis 6, Indiana.

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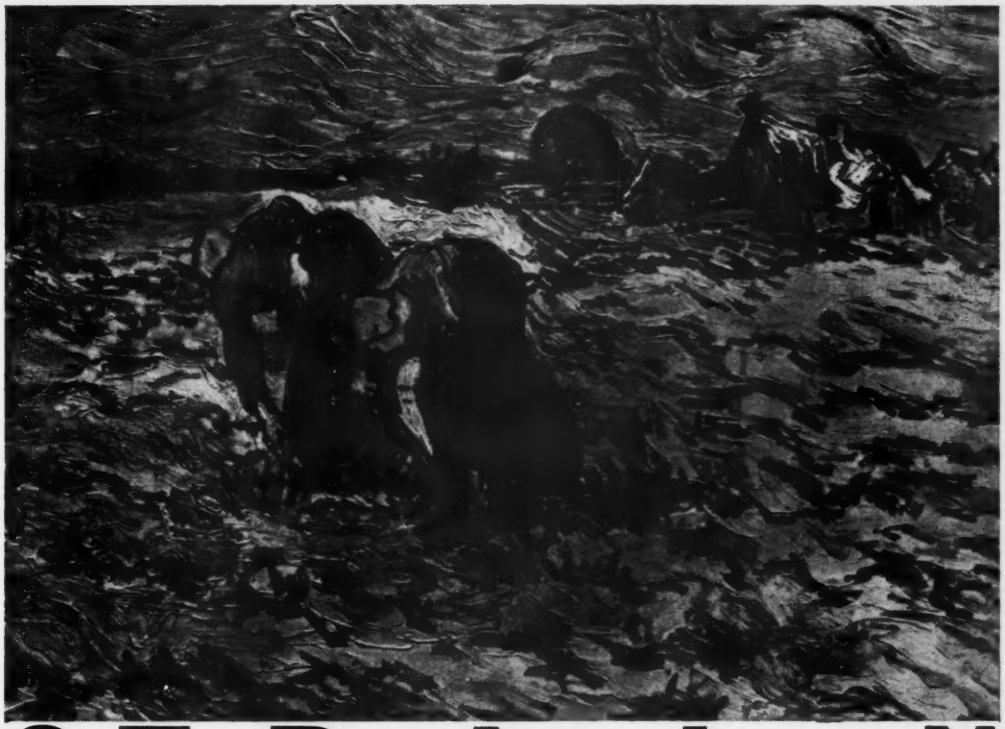
The Weeders, Van Gogh, Bernard Koehler Collection, Berlin



STRAIN

Essential in moving external masses, but potentially dangerous in moving the bowels, since vascular accidents may be precipitated in heart patients by excessive straining at stool. For cardiac patients with constipation, Metamucil adds a soft, bland bulk to the bowel contents to stimulate normal peristalsis and also to hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, induces natural elimination with a minimum of straining. Metamucil also promotes regularity through "smooth-age" in all types of constipation.

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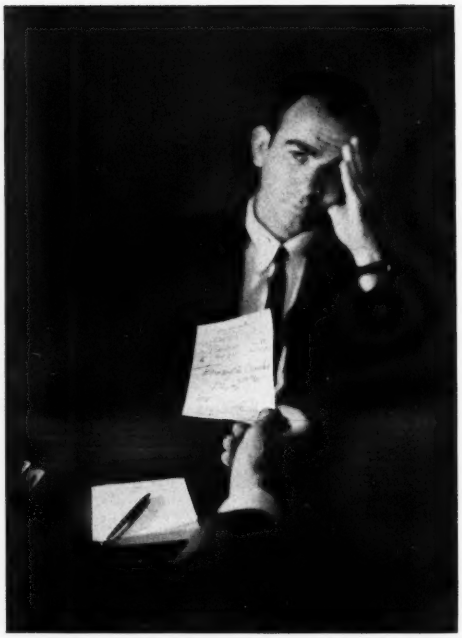
Available as Metamucil powder or as the new lemon-flavored Instant Mix Metamucil

SEARLE

According to a recent report* on the effectiveness of Terramycin in 106 cases of upper respiratory tract infection: "The response in sinusitis was particularly gratifying, as both acute and chronic cases were controlled within an average of five days."

"It was the impression of the hospital staff that oxytetracycline [Terramycin] was not only better tolerated, but more effective than other antibiotics habitually used."

The results reported in this and many other studies confirm the vitality of Terramycin for broad-spectrum antibiotic therapy and demonstrate why —increasingly—the trend is to Terramycin.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Syrup/Pediatric Drops
125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively—deliciously fruit-flavored aqueous forms . . . preconstituted for ready oral administration

TERRAMYCIN Intramuscular Solution
50 mg./cc. in 10 cc. vials; 100 mg. and 250 mg. in 2 cc. ampules—the broad-spectrum antibiotic for immediate intramuscular injection . . . conveniently preconstituted . . . notably well tolerated at injection site with low tissue reaction compared to other broad-spectrum antibiotics

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OXYTETRACYCLINE WITH GLUCOSAMINE

CAPSULES *250 mg. and 125 mg. per capsule*

convenient initial or maintenance therapy in adults and older children

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*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

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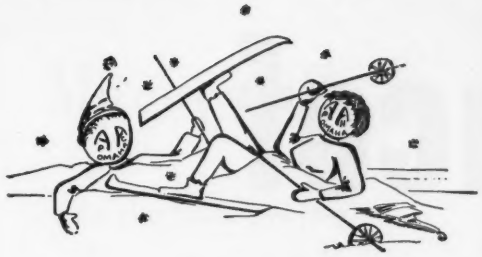

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Niedelman, M.L.: Am. Pract. & Digest Treat., 10:1001, 1959.

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Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

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Bibliography: (1) Jacobs, I.: GP *21*:93 (Jan.) 1960. (2) Shulman, I.: J.A.M.A. *175*:118-123 (Jan 14) 1961. (3) Moore, C. V., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, p. 243.

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